

MINISTRY TO SPINAL CORD INJURY PATIENTS:  
TREATMENT OF THE ANGER, PAIN, AND  
ILLEGAL DRUG USAGE SYNDROME

Chevienne Jones, D.Min.

B.S., Morris Brown College, 1960  
M.Div., Interdenominational Theological Center, 1977

Mentor

Clinton W. McNair, Ph.D.  
Lawrence Wilkes, Ph.D.

A FINAL DOCUMENT SUBMITTED TO  
THE DOCTORAL STUDIES COMMITTEE  
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF DOCTOR OF MINISTRY

UNITED THEOLOGICAL SEMINARY  
DAYTON, OHIO  
December, 2004

Copyright © 2004 Cheviene Jones  
All rights reserved.

## CONTENTS

|                                                                                              |      |
|----------------------------------------------------------------------------------------------|------|
| ABSTRACT.....                                                                                | iv   |
| ACKNOWLEDGMENTS .....                                                                        | v    |
| DEDICATION .....                                                                             | vii  |
| LIST OF ABBREVIATIONS.....                                                                   | viii |
| INTRODUCTION.....                                                                            | 1    |
| Chapter                                                                                      |      |
| 1.    MINISTRY FOCUS .....                                                                   | 4    |
| 2.    REVIEW OF LITERATURE AND STATE OF THE ART<br>PROJECT MODELS .....                      | 20   |
| 3.    THEORETICAL FOUNDATION.....                                                            | 49   |
| 4.    METHODOLOGY.....                                                                       | 77   |
| 5.    CASE STUDIES.....                                                                      | 88   |
| 6.    REFLECTIONS, SUMMARY, AND CONCLUSIONS.....                                             | 178  |
| Appendix                                                                                     |      |
| A.    REQUEST FOR AND AUTHORIZATION TO RELEASE<br>MEDICAL RECORDS OR HEALTH INFORMATION..... | 191  |
| B.    CASE STUDY EVALUATION FOR DA DRUMMER .....                                             | 193  |
| C.    CASE STUDY EVALUATION FOR LIGHT HORSE .....                                            | 199  |
| BIBLIOGRAPHY .....                                                                           | 205  |

**ABSTRACT**  
**MINISTRY TO SPINAL CORD INJURY PATIENTS**  
**TREATMENT OF THE ANGER, PAIN, AND**  
**ILLEGAL DRUG USAGE SYNDROME**

by

Chevienne Jones

United Theological Seminary, 2004

Mentor

Clinton W. McNair, Ph.D.

Lawrence Wilkes, Ph.D.

The objective was to assist Spinal Cord Injury Unit patients in the adoption of improved lifestyles, free from illegal drug usage, chronic pain, and anger responses; to improve the quality of life by reducing the level of anger and the intensity of pain that leads to illegal drug usage. Case studies were conducted and reconstructed involving Spinal Cord Injury Unit patients, reflecting instances of spiritual intervention during interactive counseling encounters and structured hospital visitations.



## ACKNOWLEDGMENTS

First and foremost, I want to praise, worship and thank Father God, His first and only begotten Son, Jesus Christ, and the Holy Ghost for the gift of their three-fold presence in me. I want to take this opportunity to thank all of the members of the administration, faculty, mentors, staff and other support services of the United Theological Seminary, Dayton Ohio; the administration, faculty, staff, mentors and support services of the Robert Schuller School for Preaching. Particularly, I want to thank Dr. Clinton McNair, Dr. Lawrence Wilkes, and Dr. Sande Herron. I thank you for befriending, teaching, encouraging and inspiring me in many ways. The time was right for me to meet people as nice as you have been to me.

Thanks to the members of this peer group for sharing who they are and what they do with new-found friends and relationships from near and far as we met and shared the Milieu, the Message, the Messenger, the Method and, most of all, the Master in new and meaningful ways.

Thank you to the administration and staff of the Louis Stokes Veterans Affairs Medical Center, Cleveland Ohio. Furthermore, we offer special words of thanks to Dr. Cecelia Williams, D.Min, Dr. Lynne Rustad, Ph.D., Mr. Claude Smith, MSSA, and Rev. James L. Hughes.

To the members and friends of the Quinn Chapel African Methodist Episcopal Church, Cleveland Ohio, thank you for your prayers and steadfast support.

To my wife, the Reverend/Chaplain Jeanne Beharry-Jones, person extraordinaire,  
for all of her hard work, encouragement and support throughout this process; thanks . . . it  
was needed then . . . and it's needed now.

May God bless and keep you, both now into the forever of all forever(s), ad  
infinitum; Happy Trails to you all, until we meet again, my brothers and sisters. Amen.

## DEDICATION

To the Members of My Immediate Family:

Wife: Jeanne Beharry-Jones, Daughters: Gina, Yahne, Maya; Grandchildren and family

Father and Mother: Rev. Dr. Lee Jerome Jones and Mrs. Tammie Lee Roney-Jones

Brother and Sister-in-law Rev. Wallace L. Jones and Mrs Fredonia Sager-Jones

Brother-in-law and Sister: Mr. Calvin Stevens and Mrs. Eleanor W. Jones-Stevens

Brother-in-law and Sister: Mr. Theophia Williams and Mrs. Helen D. Jones-Williams

Brother and Sister-in-law: Mr. Kenneth T. Jones and Mrs. Dorothy C. Rice-Jones

Daughter: Cherine Jones; Daughter: Chequetta Jones; Son: Cheviene David Jones

## ABBREVIATIONS

|      |                                              |
|------|----------------------------------------------|
| AA   | African American                             |
| AE   | Activating Event                             |
| AME  | African Methodist Episcopal                  |
| CN   | Charge Nurse                                 |
| CNS  | Central Nervous System                       |
| CPE  | Clinical Pastoral Education                  |
| DD   | Da Drummer                                   |
| HVR  | Heart Variability Rate                       |
| IBs  | Irrational Beliefs                           |
| LH   | Light Horse                                  |
| LTWS | Literal Translation Word Sequence            |
| MOS  | Military Operations Specialist               |
| NP   | Nurse Practitioner                           |
| PNS  | Peripheral Nervous System                    |
| RBs  | Rational Beliefs                             |
| REBT | Rational Emotive Behavior Therapist          |
| SCI  | Spinal Cord Injury                           |
| SIAC | Southern Interscholastic Athletic Conference |
| TA   | The Author                                   |

|      |                                   |
|------|-----------------------------------|
| TBI  | Traumatic Brain Injury            |
| TH   | Doctor Thego                      |
| VA   | Veterans Affairs                  |
| VAMC | Veterans Affairs Medical Center   |
| WSCI | Wade Park Spinal Cord Injury Unit |

## INTRODUCTION

This dissertation deals with the treatment of the anger, pain and illegal drug usage syndrome among spinal cord injury patients of the largest Veterans Affairs Medical Center in the United States of America, which is located in the State of Ohio.

Chapter One begins by presenting the author as the oldest of five children in the family of an Itinerant Elder and his wife within the Sixth Episcopal District of the African Methodist Episcopal Church, also known as the State of Georgia. Between ages one to seventeen years of age, the family of the author lived in seven different cities within the State of Georgia. The pilgrimage of ministry and the upward spiral of pastoral promotions for the father of the author began around 1946 and continued until around 1959, at which time the father and his family settled in the Metropolitan Atlanta Georgia area.

Many perceptions of what was happening to the father of the author within Episcopal District operations and the connectional politics of the African Methodist Episcopal Church were not always understood by the author in his immaturity and adolescence. Additionally, because of the hostility experienced by the author and his brothers and sisters from other children and certain adults in the various cities of his upbringing, the author was unaware of the buildup in him over the years of hidden anger and resentment. Almost all of this seething anger was centered around the author's upbringing and development within African Methodist Episcopal Church relationships, but not within his immediate family circle. After many years of actively participating in the

Christian ministry as an Itinerate preacher in the AME Church, things started to happen to the author similar to what happened to his father. Subsequently, some of things happened to him because he was his father's son. In the process of time, a "countenance changing anger" arose in the author. It was the hidden, seething, passive/aggressive habits of anger, which the author developed as a young child and as a small adolescent. Surprisingly, the author, while serving as a Chaplain Resident in the VA hospital, became aware of high levels of hidden anger within the personalities of Spinal Cord Injury trauma patients. Like the author, they too are Disabled Veterans of the United States Armed Forces.

The geographical context for this project of ministry is the Louis Stokes Veterans Affairs Medical Center of Cleveland Ohio. This VA medical center's mission is the service of disabled veterans of the Armed Forces of the United States of America. It is also a medical education and research hospital, educating students in all of the disciplines that make up the interdisciplinary teams of this multi-dimensional medical facility; the largest VAMC in the United States of America.

Chapter Two presents a review of literature and research of existing models of ministry or projects that compare favorably with the dimensions and objectives of this project. The models/projects must offer evidence of structured observations and verifiable conclusions reached under controlled conditions involving the elements within the syndrome of anger, pain and illegal drugs abuse among patients experiencing spinal cord injury trauma(s).

Chapter Three presents a Theoretical Foundation that supports a Theology of Pastoral Care for addressing the patients in this study and a Biblical Foundation in support of a ministry of Pastoral Care to the patients in this study. Lastly, a theoretical foundation of the history and philosophy of Pastoral Care is presented, which involves the inclusion of

the focus of the theological and biblical foundations of this model of ministry. It is an overview and modus operandi of their hierarchical order and interrelationship to one another in the delivery and/or realization of every ministry moment(s) in the treatment of the syndrome of anger, pain and illegal drug usage among spinal cord injury trauma patients.

Chapter Four contains the methodology and design of an instrument for the evaluation of two case studies in relation to a description of the spinal cord injury patients in this project, against the backdrop of the parameters of the stated hypothesis.

Chapter Five describes the responses and written evaluations of a Clinical Psychologist, Licensed Social Worker, Clinical Pastoral Education Supervisor, Nurse Practitioner, and/or the Chaplain to a series of questions, that evaluate the role and effectiveness of the Chaplain in the ministry to SCI patients experiencing the anger, pain and illegal drug usage syndrome. Also included is the conclusion and evaluation by the author.

Chapter Six contains the author's reflections on the case studies, and other summaries commentaries, and alternative conclusions, not included in the previous chapters.



## **CHAPTER ONE**

### **MINISTRY FOCUS**

The author is 62 years of age and married, the oldest of five children of a retired Itinerate Elder of the African Methodist Episcopal of Atlanta, Georgia. The author has two brothers and two sisters, all residing in the state of Georgia. Previously, the author served as a pastor in the cities of Cincinnati Ohio, and Erie Pennsylvania of the Third District of the African Methodist Episcopal Church. Presently, the author is employed as the Pastor of the Quinn Chapel Church, Cleveland OH, of the Third District of the African Methodist Episcopal Church, since November 5, 2001. Historically, the author served as a pastor in the cities of St. Louis Missouri (twice), Kansas City Missouri & Kansas, and Los Angeles California (twice) in the Fifth District of the African Methodist Episcopal Church. Furthermore, the author served as a pastor in the cities of Calhoun Georgia, Sylvester Georgia and Macon Georgia of the Sixth District of the African Methodist Episcopal District. The author has been in ministry for twenty-seven years.

The author was born in Albany, Dougherty County, Georgia, 02/22/1942 at 7:30 AM. The author was raised in the home of a black southern Methodist preacher and grew up in parsonages all over the State of Georgia, also known as, the Sixth Episcopal District, of the African Methodist Episcopal Church. His dominant characteristics and cultural background were formed within the context of the African Methodist Episcopal Church in parsonages, preaching, and with other preachers and their families. When the

author first came to know himself as an individual, he was on the front steps of the parsonage of New Hope AME Church, Smithville, Georgia, watching a “king snake come into our front yard looking for food.” His mother used a hoe to kill that snake. She said to him, “Baby, be on the lookout for the king snake’s mate, they travel in pairs.” Sure enough, just before sundown, the other snake came from under the front steps following in the trail of its mate. The author yelled aloud to warn his mother of its arrival. His mother used that same hoe to kill that snake also. Leaving from Smithville Georgia, the family moved to Alien Chapel AME Church, Americus Georgia; then to Atoc AME Church, Dawson Georgia and then to Grays Chapel AME Church, Macon Georgia. Subsequently, the family moved to Antioch AME Church, Decatur Georgia, in the Metropolitan Atlanta Area in 1958.

As the oldest of the five children, his brothers and sisters depended on him for leadership among the siblings, leading the family’s assault team. Though he was older and larger than his brothers and sisters, he was still smaller than the other big brothers and big sisters in their neighborhoods. Even when he was afraid and outmatched, he would still take his place as the leader of the family gang in the time of crisis and trouble.

The author was musically gifted from his youth, possessing a clear, very high-pitched voice. Though he sang very well, other children made fun of his soprano sounding voice. The author wanted to play the piano, but stopped taking piano lessons when an effeminate music teacher made a pass at him. He got up and ran from that house and never returned. The author never told his parents or anyone one else about what happened to him. Instead, he asked permission to play sports and then joined the football, basketball, baseball, and/or track teams. Comparatively speaking, the author was still small in stature when he entered high school. Bullies picked on him when he first entered high school and

his voice was still high-pitched. The author did not realize that many of his problems stemmed from the fact that he entered elementary school at an early age and then was skipped a grade while he was in elementary school. In actuality, the class of his peers, in both size and development, was two grades behind him. The author's classmates had entered the adolescent growth spurt two years before he did. Consequently, they were bigger because they were older. The anxiety and frustration that the author experienced about his physical size and the high pitch of his voice was due to the fact that his classmates were two to three years older than he was. The author thought that he would escape that hostile environment when he took the college entrance examination in the tenth grade, at the age of fourteen, in Macon Georgia. He passed the test, but his father decided that he was too young to go to college, not even on a full scholarship. The author responded to his father's decision with being angry because he thought that he was being held back and his opportunity to escape peer pressure was being closed down. In fact, he even stopped trying to excel in school academically because he thought his father had treated him unfairly. The author did not come to appreciate his father's decision for him until many years later. In actuality, going to college at age fourteen would have simply compounded his problems of adjustment and development during his struggles of adolescence and pubescence and would have exposed him to various kinds of older and larger predatory individuals that populate many college campuses.

Before leaving Macon Georgia, in the late 1950's, his whole family was infected with the mumps. The only exception to this infection of the mumps was his older sister, the third child of the family. She was a little girl, running from room to room, from person to person, bathing each family member in sardine oil and trying to give aid and comfort wherever it was needed. The author was the only one that the mumps affected adversely.

The author was told that, if the mumps “went down” on a male child, he would probably be sterile for the rest of his life. The author operated under the assumption that this was a true assessment until he was confronted with evidence to the contrary, many years later.

Upon finishing high school, at 16 years of age, and entering Morris Brown College as a scholar and athlete, the author’s father moved on to pastor multiple congregations in the Metropolitan Atlanta Georgia Area. In 1960, his father began serving Turner Monumental and Cosmopolitan Churches, in the Atlanta-North Georgia Conference. He was then raised to the office of Presiding Elder of the South Atlanta District. He returned to the pastorate at Saint Paul AME Church Atlanta Georgia, and was then moved to Presiding Eldership of the East Atlanta District, returned to pastor Big Bethel AME Church Atlanta, on sweet Auburn Avenue, and then moved eastward to Bethel AME Church Savannah, Georgia. After a series of political battles and subsequent changes in Episcopal administration, his father returned to the South Atlanta District of Atlanta, and remained there until his retirement in May of the year 2002.

The AME Church was the dominant factor in the life of the author. It was the crucible for the formation of much of his personality, intelligence, talents, interpersonal relationship skills, mores, folkways, likes and dislikes. His first “unique playground,” away from the house and neighborhood was in the “Amen corner” of Alien Chapel AME Church Americus Georgia, where he crawled under benches, and rubbed and played with the older ladies legs. His father never stopped preaching. He simply came down to where the author was playing, reached under the benches, pulled him out, turned him over, and spanked him repeatedly on his butt. He then drew his son to his face and said to him; “dry it up, and don’t make a sound.” Finally, his father sat him down hard on the last seat in the pulpit and kept him near him until after the preaching and the service was over.

The AME church was the place that the author first heard his father sing melodiously as a baritone and tried his best to mimic that beautiful low voice over and over. In the churches, the author sang in the choirs, in groups of quartets, trios, in duets, and sang solos. The author began with a soprano voice, then moved down to alto, tenor, baritone, and bass. To this day, the author still retains a very wide and spirited vocalization range. For the author, it all began in the AME Church environment.

There was no change in the Mosaic development of his personal history until he reached the City of Atlanta Georgia, 1958. The author did not want to go to Atlanta Georgia because of his strong interest in school, academics, and athletics in football and basketball and in a certain girl. She was number two in the graduating class of 1959 in Macon Georgia.

Suddenly, there was Metropolitan Atlanta, a strange and yet exciting place to be. Graduating from high school, and joining the Cooperative Experimental Summer School Program, sponsored by the Ford Foundation, and then entering Morris Brown College within the Atlanta University Center Complex, was a fantastic experience. Simultaneously, it was a dangerous place for the unlearned and untutored in the ways of life and the ways of streets of the city of the early 1960s.

The author was graduated from Morris Brown College in 1963, with a B.S. Degree in Mathematics. It was a very versatile degree to possess in the job market of the 1960s. The Western Electric Company Incorporated employed him as a Telecommunications Engineering Associate writing electro-mechanical specifications for central switching offices for the Southern and South Central Bell Telephone Companies. The author was one of the first ten African-Americans hired in that position in the city of Atlanta Georgia. It was a very hostile, violent and intensely prejudiced atmosphere, to say

the least. The Federal Government of the United States of America decreed that every company doing business with the Federal Government had to comply with equal opportunity laws in their employment practices. For the most part, the white people did not want them there and management kind of stood off, watched the racial fireworks, and tried to take advantage of every seeming weakness exhibited by their young African-American employees in these racial conflicts. Against all odds, these young employees prevailed in those positions. Their successes paved the way for future employees. It is important to note that, even in the midst of this racial turmoil and controversy, dating across racial lines flourished secretly in both directions. It was fueled by propinquity and curiosity about the alleged "forbidden fruit." Also, the questioning of racial taboos caused him and others to experiment as individuals from time to time. Others participated out of the spirit of adventure and for the adrenalin rush experienced from scarcely escaping detection. The author learned that there are good and bad white people, just as there are good and bad black people. In the final analysis, we must meet each person as an individual and refuse to prejudge anyone based on a preconceived notion of character and/or identity.

The author received his call to preach when he was in New York City in 1972. He remembered that it was the same day that Duke Ellington died. He did not fully acknowledge his calling until he returned to the Saint Paul AME Church Atlanta Georgia, in 1974 when he came forth and put his hand in his father's hand. In 1972, the author experienced a theophany that lasted for over an hour. In that theophany, he saw a large golden wagon wheel with spokes and a unique hub. The spaces within the spokes were black, and the golden wheel was turning in a clockwise direction. The hub of the wheel was in the shape of a golden helmet like the one on the national florist emblem. The helmet

reminded him of the golden hat of Hermes, the messenger of God. Then he saw “the pine tree walls” of an army fort, like the ones in days of the U. S. Calvary of the old west. On the walls he saw an expression, which had been burnt into the walls of the fort with fire. The burnt expression was still smoking. It said, “A.M.E. CHURCH.” And the author said, “O Lord, not them, not them, Lord.” Jesus said to him, “Yes, I have chosen them and you must stay among them.” The author said; “but Lord, they are mean and evil people. I have seen first hand how they have treated my father and mother over the years. If at all possible, can I serve through another group?” Jesus said, “No. I have chosen the AME Church for you; go and serve among them.” (By the way, the author experienced that same theophany on two separate occasions after trouble had erupted. It was to remind him not to leave the AME Church for any reason.) Subsequently, the author had a vision of a young black woman lying on her back on a bed with a black baby boy lying face up on top of her. She seemed to be praying and the baby boy was screaming to the top of his voice. The Lord made the author to know that the young woman was his mother and that he was the crying baby boy. When he arose from his theophany the first time, he called his mother and asked her this question. “Momma, was I supposed to die when I was a child?” She paused for a long moment and asked him this question, “who told you that?” The author said, “Momma, I saw it in a vision, and also saw you as a young woman praying for me.” She paused for a moment and said, “Baby, when I was a young woman, the doctors told me that I would never have children.” After consulting with many doctors, she was giving up hope. But as she was leaving the office of her last disappointment, the Spirit spoke to her and said; “but have you asked God about it?” The author’s mother went home and prayed for a very long time. In the process of praying, she asked God for three children and she promised that she would give them back to Him. Then she said, “on

the occasion of which you speak, there was a whooping cough epidemic in the United States in the early 1940s,” and she had determined that since the author was her baby, no one was going to stick her baby with a needle. The author got sick unto death and his life was slowly slipping away when God spoke to his mother and said, “But I thought you said that you had given your boy back to me.” Immediately, she asked forgiveness, repented of her sins, in the name of Jesus, and restated her promise and commitment to give her children back to the Lord. The mother said that in less than an hour, the author was crawling around on the floor, playing with toys like nothing had ever happened. From that experience, the author knew that beyond the shadow of a doubt, the purpose of his birth was to be a preacher, teacher, a messenger, purposed to a man of God, even before he was born. Whether he proclaims it or not, the author knows that he is somebody special in the mind and in the eyes of his Heavenly Father, the Lord Jesus Christ and the Holy Ghost. The author has not lived a perfect life, but it is the life the author has lived. Time and time again, God has snatched victory from the jaws of defeat, on his behalf. By the design and/or providence of God, he is who he is, and God has caused him to overcome and even triumph over trials, struggles, circumstances, problems, diseases and discomforts. The author willfully accepts, and intentionally embraces, his cultural heritage, and all of the experiences he has amassed in the past, in the name of Jesus Christ, to the glory of Father God, unto the present day. Praise the Lord!

In the process of growing up as a member of an itinerate ministerial family in the African Methodist Episcopal Church in the State of Georgia, the author experienced a sense of grief and loss on many occasions as his family moved from place to place. From 1947 to 1951, they lived in Americus Georgia. From 1951 to 1955, they lived in Dawson Georgia. From 1955 to 1958, they lived in Macon Georgia. In 1958, they moved to



Decatur Georgia in the Metropolitan Atlanta area. Approximately every four years, they moved to a different city, leaving familiar friends and surroundings, and then greeting strangers and some degree of hostility in unfamiliar environments. The author was the oldest of five children. More often than not, he was smaller than the oldest child in most of the families that they encountered in their travels. Because they were the new kids of the block, they were often picked on, made the brunt of jokes, ostracized, and physically attacked by the children of the newly encountered strangers in unfamiliar environments. Just as they were about to get used to familiar friends and surroundings, his father would get a promotion to another church in a different part of the State of Georgia. No matter how much he protested, his father and mother would never allow the family circle to be broken. All of us had to stay together and support one another. We were a family.

From age 5 to 9, the author can only remember a few of his friends from Americus Georgia: Edna Earle Hubbard, Robert Hubbard, Thomasine Blount, James Lawrence Bryant, Virginia Pae Moses, Nathaniel Anderson, Charlie Hopkins, Willie Albert Hopkins, Anna Maude Hopkins, and Donnie Earle McDonald. All of them attended McCoy Hill School. The author remembers Mrs. Sharpe, Mrs. Driggers, and Mrs. Fluellen as excellent, caring teachers. The author remembers playing hard and competing fiercely, in all manner of academics, sports, community and church-sponsored activities. The author did not have time to get ready to go or to say goodbye. They were there one day and the next day they were gone bye-bye.

From age 9 to 13, the author can only remember a few of his friends from Dawson Georgia: Robert Albritton, Billy Roy Ward, William Bell, Helen Sykes, Kay Gordon, Samolynn Price, Cora Weston, Nellie Florence Williams, Earlene Williams, Roy Chester Patterson, Wally Moon and Clovis Jones. All of them attended Carver School. The

Rosenwall Family Foundation built that school as well as many other schools for the education of black children. The author remembered Mrs. Sykes, Mrs. Anderson, Miss Reed, Miss Pettigrew, Mister Robert Stefan Johnson as good teachers, and Mister E. E. Sykes as a fine Principal. The author was continuing in the development of his prowess as an athlete, scholar and vocal musician. Once again, he did not have time to say extensive goodbyes. They packed up all their things in one day. Early in the morning, some men from the church in Macon Georgia came to help them move. They loaded up early in the morning before sunrise, said a few goodbyes and they were gone.

The author recalls an experience of great grief and loss when the family dog named Prutt died. They did not see it happen, but they believe that a white mailman stabbed the dog, and caused him to lose a lot of blood. Prutt died very slowly. He whimpered and groaned and all of the children and his mother cried and wept for many days. He was a very intelligent dog, an elite member of the Jones' Fighting Brigade. He was a fast member of their family. He was a house dog. Prutt was the only dog that his parents liked and/or tolerated. They tried to bring other dogs into the family circle later on, but none of them could make the grade. So, they stopped trying to fill that void.

From age 13 to 16, the author was in high school at Ballard-Hudson High School, in Macon Georgia, a very large "AAA" class high School. They were Georgia State Champions in basketball, football, baseball, track and volleyball. Likewise, that high school was rated as one of the best high schools in the Southeastern part of the United States. The author was privileged to take college level courses in Mathematics, and performed Chemistry and Biology projects and experiments at Mercer University in Macon in the late 1950's of the segregated south. The author's friends were too numerous to mention. However, the author will name a few: Clara Chapman, Morris Head, William

Alfred Head, Johnny Smith, James Green, Prince Hall, Cleveland Singleton, Bennie Singleton, Alvin Dark, Bo Diddley, James Hill, Johnny Jenkins, James Brown, Otis Redding, Little Richard Penniman, Sarah Chapman, Charlsie Chapman, Annette Bozeman, Laura Nell Sinclair, Agnes Lightfoot, Lemuel Stone, Carolyn Hudson, Evelyn Warner, Bernard Brown, Charles Howard, Peyton Carswell, Douglas Willis, Leona Bonner, Mildred Purnell, Precious Bailey, Alice Bailey, and Carrie Davis. For the author, life was very good. It was good to be around so many people who wanted to learn and to be in an environment where scholarship was encouraged, appreciated, and openly rewarded. The author remembers Miss Pitts, Mrs. Carrie Wright, Mister A. C. Kellum, Miss Ernestine Fields, Mrs. Driskell, Mrs. Thompson, Mister Wynn, Mister Slocum, Coach Mitchell, as good people and good teachers. When his father told them that they were moving to the Metropolitan Atlanta Area, they thought that it would be grand. But when they arrived, it was in a city called Decatur Georgia, at a very small Class "A" School. Almost all the children tried to be slick and cool. The boys hung out on the corner block, messing with passers by, drinking, smoking and talking trash. They made fun of the author and his family members because they were good students, talented, and the new kids on the block. The author wanted to return to Macon Georgia, as quickly as possible, but it didn't happen. He begged his father to let him finish high school there, but his father would not grant his request. The author was so hurt and grief-stricken that he stopped studying and trying to excel in anything. Additionally, there were very few students in Trinity High School, Decatur Georgia on that kind of an agenda. The author became rebellious and angry with his father because he would not allow him to return to familiar friends and surroundings in Macon Georgia. The author did not begin to recover from these

experiences of grief and loss until he was well into his sophomore and junior years at Morris Brown College, Atlanta Georgia, 1961.

While participating in an All-City Basketball Tournament practice in Atlanta Georgia, the author turned over his ankle so badly that he could hardly walk for approximately two to three months. His ankle remained weakened and was prone to giving out unexpectedly for nearly two years. He was severely hobbled during that period of time. His behavior and attitude did not facilitate the healing process. There was no rehabilitation program or sports injury practitioner available to him. He was a small basketball player, about 5'8." He needed to regain his quickness, speed and mobility, in order to make the team. He never sat out of practice long enough for his ankle to heal properly. Sadly, he had to change his personal goal from making the starting college team to just trying to make the team. Eventually, the author made the basketball team his sophomore year in college, played in some home games, and took pictures for the yearbook as a member of the Morris Brown College Basketball Team, SIAC Champions of 1961, under Coach "Cab" Green. He made the team as a secondary objective, but he never played up the level of his previously exhibited potential.

#### **Four Hospitals Became One Veterans Affairs Hospital**

The overall context for the interface of the life and experiences of the author with the angry subjects who will be the target of ministry will be the Louis Stokes Veterans Affairs Medical Center, of Cleveland Ohio.

The history of the Cleveland Veteran Affairs Medical Center is in essence, the story of four VA Hospitals: Broadview Heights, Crile, Brecksville and Wade Park. The old Broadview Heights Hospital was located on property four miles west of Brecksville,

Ohio that was donated to the Veterans Administration by the City of Cleveland in 1938. Originally, contracted as a general medical unit, the first patient was admitted on November 1, 1940. With World War II upon them, a decision was made to construct a U.S. Army Hospital in the Cleveland area and construction started on April 13, 1944. The first patient was received on April 21, 1945. Named after General George Washington Crile, a Cleveland surgeon who led the first hospital unit to land in France during the First World War, the Crile Army Hospital functioned until June of 1946, when it was turned over to the Veterans Administration as general medical and surgical hospital and established as a 1,000-bed unit.

In July of 1946, the Broadview Heights Hospital was converted from general medical and surgical to one for the predominant treatment of Tuberculosis and, with the addition of two new wings in 1951, attained a bed capacity of 278. With the return of millions of servicemen from World War II, the VA entered into a nationwide program of hospital building and modernization.

January of 1956 saw the construction start of a 999-bed hospital in Brecksville, Ohio for the primary treatment of psychiatric patients. The first patients were admitted to the new Brecksville Hospital on September 5, 1961. At that time, the old Broadview Heights Hospital and the new Brecksville Hospital functioned as a single entity with two units. Both were under the same director and staff. This arrangement continued until August of 1965 when the Broadview Heights Unit was closed due to the scientific advances that were made in the treatment and complete elimination of Tuberculosis. The property at Broadview Heights was transferred to the State of Ohio and today it serves as a center for mentally retarded children.

In June of 1964, the Veterans Administration formally dedicated the new 786-bed facility located at University Circle complex that includes Case Western Reserve University and Medical School, University Hospitals, Mt. Sinai Hospital and other institutions dedicated to medical, cultural and spiritual attainments in the community. The old Crile property was donated to the county and today serves as the Western Campus for Cuyahoga Community College.

From 1965 until 1973, both the Brecksville and Cleveland VA Hospitals continued to operate as separate VA facilities, each with its own director, staff, and budget.

In July 1973, the Cleveland Hospital, now known as the Wade Park Unit, and the Brecksville Unit were consolidated into the present Cleveland Veterans Administration Medical Center, operating with one director, one staff and one budget. Finally, in September of 1980, the VA Outpatient Clinic at Canton, Ohio opened to serve the outpatient needs of veterans in a nine county area surrounding Canton. This recently opened facility is also a part of the Cleveland VA Medical Center. It is now the largest VA Medical Center of its type in the country.

The Author's unique approach to ministering to the Spinal Cord Injury population of the Louis Stokes Veterans Affairs Medical Center and the utilization of his theological perspective of Pastoral Care is qualified by a near-death experience that he had during his years as an undergraduate college student at Morris Brown College in Atlanta Georgia. The author experienced a terrible automobile accident, while driving his father's white, four-door, 1960 Pontiac Catalina. The car was completely demolished when he crashed into a giant oak tree. The car was so badly damaged that his father would never let him see the wreckage, they just told him about it. The police officer attending to the scene of the accident said: "I know that the driver of this car is dead because no one could have

survived this crash and lived.” The friend told the officer that the author was alive. Then he said: “if he did survive, he will be crippled for life.” The author is pleased to report that he not only survived that serious accident by the grace of God, but he prevails to this day, to the glory of God in spite of his historic worldly lifestyle and his litany of selfish personal choices. Therefore, instead of being ministered to as a possible paraplegic or quadriplegic with a significant degree of neurological impairment and trauma, the author has been spared the agony, trials, and suffering of that crippling experience of physical, mental and spiritual anguish. On the contrary, the author is blessed to minister to the traumatized population of the Spinal Cord Injury population at this hospital as an intentional caregiver, and as a willful participant in the body of Christ. But for the grace of God, the author would be a paraplegic or quadriplegic patient. There is no sense of personal perfection registered in his mind or in his heart. The author is a sinner, saved by grace, but a sinner, nonetheless.

### **The Chaplain’s Pain and Anger, Mirrored that of the Traumatized Patients**

Given the fact that the author is a disabled United States Air Force veteran with occasional lower back pain issues, he has something in common with Spinal Cord Injury patients. Additionally, during the first half of his residency as a Chaplain at the Louis Stokes VAMC, the author experienced a recurring and agonizing bout with the gnawing and excruciating pain of the sciatica nerve in his right leg. No matter what he did in terms of treatments, therapies and/or prescribed medications, the chronic pain and physical discomfort just would not go away. As best he can remember, the author was predisposed to dealing with the level and/or intensity of his pain as a high priority. During that period of time, the author was not given to engaging in unnecessary conversation about his

private and/or the personal life of others. The author was consumed with self-interest issues in one way or another. The author just wanted relief from chronic pain, physical discomfort, and personal space to be preoccupied with himself and his concerns.

In the process of serving as a Chaplain Resident and acknowledging the intense levels of anger and amounts of pain harbored by many SCI patients, the author became aware of his own unresolved pain and anger issues. This pain and anger stemmed from the protracted interface of his family with the leadership, structure and membership of the African Methodist Episcopal Church. Also, after many years of actively participating in the Christian ministry as an Itinerate preacher in the AME Church, things began to happen to the author similar to what happened to his father. Subsequently, some of things that happened to him were because he is his father's son. A "countenance changing anger" arose in the author. It was the hidden, seething, passive/aggressive habits of anger, which the author developed as a young child and small adolescent. The author realized that he was just as angry and pain ridden as many of the spinal cord injury patients on a spiritual, emotional, and psychological level, being either unwilling and/or unable to express openly.

95 to 98% of the Spinal Cord Injury patient population is either angry or very angry. Some of the anger is subtle and some of it is overt. Comparatively speaking, these angry patients are in a traumatized state and the staff members are in an untraumatized state. The patients are angry because they cannot care for themselves. Furthermore, they are angry because they have to depend on untraumatized people for assistance in almost everything. They look at the doctors, office workers, and staff members as being in an untraumatized state. In other words, the doctors, office workers, and staff members are the enemy because they are reasonably healthy and have mobility.



## **CHAPTER TWO**

### **REVIEW OF LITERATURE AND STATE OF THE ART PROJECT MODELS**

#### **Review Of Literature**

Generally speaking, there is much literature and many articles relating to the treatment of the victims of trauma and post-traumatic stress syndrome in the field of mental health. For this study, the author will review literature that relates to the identity of Chaplain and/or Pastor in crisis intervention.

In his book entitled *The Christian Pastor*, Wayne Oates gives us a perspective of pastoral work and the development of the pastoral identity in ministry. Although the primary focus of the book deals with the function of the pastor in a Christian church setting, the pastoral dynamic is transferable to the function of a Chaplain in a hospital setting. Oates speaks of the pastor being present to intervene and support the person at the time of crises and the instances of trauma. In the mind of some patients, the Minister/Chaplain is perceived as the presence of God and the embodiment of the love of God. Oates acknowledges the presence of the Holy Spirit in the work of the ministry of care-giving. Oates also suggests that pastoral authority must be handled with great care, especially at the time of crisis when people are most vulnerable. In the delivery of ministry, the caregiver must attempt to help and empower the people in crises.

Oates describes the level of intimacy that is given to the Pastor and or the Chaplain as having three characteristics:

- Accurate empathy,
- A non-anxious presence, and
- An inherent genuineness.

Psychologically, these characteristics form the basis for identification with the persons in crises and/or the victim of trauma. In this process, the Pastor and/or Chaplain experiences the feelings and concerns of another person because of the love and compassion he/she has for the person and the desire to be together with them. Therefore, because the Pastor or Chaplain represents the importation of the presence of God into the identification moment of togetherness, an act of worship becomes an intricate part of the intervention. Within the context of this hierarchical relationship with the Godhead, the fear of rejection is a non-issue for the Pastor or Chaplain, as an intentional caregiver.

In his book entitled, *The Presence of God in Pastoral Counseling*, Wayne Oates portrays the presence of God as the unseen participant in the counseling process. In Chapter Five, Oates discusses the presence of God in strange events and God and His representatives as the strangers who happen along. Matthew 25:35 (KJV) said: "I was a stranger and you took me in." He also discusses how the community of faith must be a welcoming community. "Be not forgetful to entertain strangers: for thereby some have entertained angels, unawares." The spinal cord injury unit is a traumatic environment of strangers who have experienced some degree of physical, mental and/or spiritual fragmentation and/or estrangement. Initially, the Chaplain and patients are strangers to each other. They are people of different lifestyles and ethnic backgrounds with different attitudes, values and orientations. Oates makes reference to the fragmentation between Jacob and Esau, a fractured relationship between twin brothers. Family fragmentation is frequent among SCI patient families who break up after an injury that leaves them as

victims of paraplegia or quadriplegia. The welcoming stranger is an opportunity for healing and reconciliation among family members wrestling with the cumbersome reality of a partially or totally dependent victim of trauma. For the Chaplain/Pastor, it is an opportunity to intervene and identify with this family in their time of need and/or chaos. In the midst of such chaos, people search for the meaning of it all and search the horizon of the approaching day for a blessing

Oates lifts up the idea of a “stranger” when he says:

I have been in this dilemma more times than I can remember. The presence of Christ here is not experienced as a “sweet spirit in this place.” When I begin to feel profound repugnancies, I like to remind myself of what Moses said and did when he saw a strange phenomenon in a *burning bush*. “I will turn aside and see this great sight, why the bush is not burnt.”<sup>1</sup>

To turn aside from old habits and familiar behavior, understanding people and spirits, from typical thinking, and to marvel at the strange phenomenon that counselor or visitor brings to me is a discipline of great worth to cultivate. From a much different philosophical framework, Edmond Hurl calls this gift “the discipline of the naivety.” He declares that: “When we do not abandon these theses we have adopted, we make no change in our conviction. When we set out as if it were out of our own action, we disconnect.”

Dr. Williams states that:

Being open to experience this, we assume a childlike attitude to open and welcome empathy of the strange persons sitting across from us. We make room for them in our world. As we do, we are promised that we will see the Lord Jesus Christ. I can relate to setting aside my assumptions and my agenda for the moment, to explore with people what it means to be in their crisis situation and to journey with them and witness the presence of God. It is my goal

---

<sup>1</sup> Wayne Oates, *The Presence of God in Pastoral Counseling* (Waco TX: Word Publishing, 1986), 61.

to make the strange place less strange, and to make the stranger a new, and welcomed friend.<sup>2</sup>

In the annals of Pastoral Care and Counseling, Henri Nouwen's book *The Wounded Healer* is a classic. The author's acquaintance with this book goes back to the days of as an undergraduate. Nouwen makes inquiry into what it means to be a minister in this modern society. Nouwen searches for the answer by entering four "doors":

- The condition of a suffering world,
- The condition of a suffering generation,
- The condition of a suffering person, and
- The condition of a suffering minister.

Through the door of the condition of a suffering world, Nouwen examines the human predicament of having lost faith in the possibilities of life and the trade-in for technology. Nouwen states that technology is powerful but it lacks the capacity enable humanity and cause them to reach the extremities of their creative possibilities.

Through the door of the condition of a suffering generation, Nouwen sees the fragmentation and disintegration of the family caused by the social, psychological, political and economic upheavals in our society presenting alternative family model constructs, and alternative roles for members within these alternative family models. In looking for balance, Nouwen suggests that our tendency is to direct pain toward one another and to turn on one another. He reminds that God is still on the throne. God is in the midst of his servants, as they attempt to minister to members of a suffering generation.

---

<sup>2</sup> Cecelia A. Williams, "Pastoral Care to African American Males, ages: 18-35. Victims of Violence and their Families" (D.Min. thesis, United Theological Seminary, 1998), 18.

The condition of a suffering minister, Nouwen points to the wounded minister, as he/she attempts to minister to a suffering generation, in the midst of a suffering world, as he attempts to give them help and guidance as they fight for their lives. In the process of trying to address countless painful situations, the minister must try to bring hope into an otherwise hopeless situation of the suffering person. Above all else, the minister must be aware of his own wounds and let the God of all comfort heal him. He can then minister out of his healed wounds. In ministry, a servant of God must be prepared to be a vessel of care-giving that God can use to heal the wounds of others, and to be a witness to the living truth that the wounds that cause us to suffer can be healed by God in the process.

Cecelia Williams further states that: "Ministers are called to have an attitude of hospitality that allows others to enter into the minister's life through the intimate contact of those who are fellow sufferers."<sup>3</sup>

### **Review Of State Of The Art Project Models**

There is much to be learned from researching existing models of ministry and in determining the degree to which the author can become informed by the structured observations and explored conclusions of others whose focus of ministry compare favorably with the parameters of this project. The author is interested to know what the latest research data reveals about the occurrence of drug abuse, both before and after the advent of a spinal cord injury trauma.

The intensity and agony associated with chronic pain is a primary issue for many spinal cord injury patients. The syndrome of anger, pain and drug abuse, simply add to the

---

<sup>3</sup> Ibid., 24.

complexity of life, health and overall well-being of spinal cord injury patients. Those who experience spinal cord injury trauma and anger can fall into repetitious cycles of the destructive behavior of drug abuse and recidivism. These counterproductive cycles of behavior resulting from spinal cord injury trauma can cause such negative consequences an increase of pain, anger, fatigue, tension, frustration, and the agony that comes with the anticipation of more pain.

### Substance Abuse Patterns among Identical Twins

The article that the author presents for your reflection, deals with the relationship of spinal cord injury trauma to alcohol. The project involves a study of twins from the same fertilized egg (i.e., monozygotic doubles or identical twins).

**Background:** Substance misuse frequently is correlated with serious trauma such spinal cord injury (SCI). Two hypotheses to this effect are: (a) substance abuse predates injury and is a risk factor or trigger for serious injury such as SCI; or (b) substance abuse begins post injury, and alcohol or other drugs are used to ameliorate the physical and emotional distress that result from SCI.

**Methods:** To test these two hypotheses, 1. 4 pairs of monozygotic twins, in which 1 of each pair had sustained an SCI, were studied. The twin without SCI was used as a control for pre-injury substance misuse status for the twin with SCI.

**Results:** No significant differences between SCI and non-SCI co-twins' substance use patterns were found.

**Conclusions:** These findings suggest that drinking patterns might not be significantly affected by SCI and that substance misuse might precede injury.<sup>4</sup>

---

<sup>4</sup> M. Seltz, and C. Radnitz, "The relationship of spinal cord injury trauma to alcohol misuse: A study of monozygotic Twins." *Journal of Spinal Cord Medicine*. (2004) Baumam WA.. PMID: 15156932 [Pub Med - indexed for MEDLINE]. Fairleigh Dickinson University, Teaneck, New Jersey 07666, USA. <http://www.ncddr.org/du/products/saguide/SubAbuse2ndEd.pdf>. Internet; accessed 20 September 2004.

In other words, the researchers concluded that there was no genetic predisposition towards substance abuse, neither pre-injury nor post injury, among identical twins.

### Pre-injury Drug Usage Versus Post-injury Drug Usage

From a publication dealing with the commonality between traumatic brain injury patients and spinal cord injury trauma patients, we offer an article dealing with a comparative study, of both pre-injury and post injury substance abuse.

**Primary Objective:** To identify the patient population at greatest risk for post-injury adjustment problems, the present study independently examines and compares alcohol and drug use rates in patients with traumatic brain injury (TBI) and patients with spinal cord injury.

**Research Design:** The two samples were matched with regard to age, gender and mechanism of injury. The study provides a description of post-injury use rates for each population, and describes similarities and differences between the two groups.

**Methods and procedures:** Participants included 30 consecutive Model Systems spinal cord injury (SCI) patients seen for follow-up neuropsychological testing between, October 1996 and June 1999. An equivalent number of Model Systems TBI patients, were matched from a larger sample comprised of 440 consecutive hospital admissions that returned for a one-year follow-up, neuropsychological evaluation between, February 1989 and December 1998. All participants were treated in an urban Level I trauma centre and associated inpatient rehabilitation programs. Information regarding patient demographics, as well as pre-injury and post-injury psychiatric, employment, academic, criminal, and medical history was obtained via the General Health and History Questionnaire.

**Main Outcomes and Results:** With regard to post-injury alcohol use rates, persons with spinal cord injury were more likely to drink on a daily basis. Although not statistically significant, pre-injury drinking rates differed from post-injury rates for both groups. With regard to illicit drug use, persons with TBI differed significantly from persons with SCI. A significant difference was also noted between pre-injury drug use and post-injury drug use for both groups.

Conclusions: Persons who drink post-injury are unlikely to be “light” or social drinkers. Either people choose to abstain completely or appear to use alcohol frequently.<sup>5</sup>

In other words, a high percentage of post injury spinal cord injury trauma patients tend to be heavy drinkers attempting to use excessive amounts of alcohol as a form of self-medication.

#### Frequency of both Pre-injury and Post-injury Drug Usage

This is one of the earliest studies conducted on the frequency of the incidence of both pre-injury and post-injury drug abuse among both traumatic brain injury patients and spinal cord injury patients.

Alcohol and drug use at the time of injury have been strongly implicated as causal factors of spinal cord injury (SCI) and traumatic brain injury (TBI). Researchers have only begun their efforts to investigate the pre-injury incidence of substance abuse in an effort to identify persons at risk for traumatic injury. No studies have compared brain and spinal cord injury populations. This investigation was based in an urban, level one trauma center federally designated as a model system of comprehensive rehabilitative services for persons with TBI and persons with SCI. Pre-injury patterns of alcohol and illicit drug use were compared among patients with SCI and patients with TBI, matched for age, gender, race, and mechanism of injury (n= 52). In accordance with previous research, participants were primarily young, unmarried, males, with at least a high school education. Eighty-one percent of patients with TBI and 96% of patients with SCI reported pre-injury alcohol use. The rate of pre-injury heavy drinking for both groups was alarmingly high. Fifty-seven percent of persons with SCI and

---

<sup>5</sup> S. A. Kolakowsky-Hayner, E. V. Gourley 3rd, J. S. Kreutzer, J. H. Marwitz, M. A. Meade, and D. X. Cifu, “Post-injury substance abuse, among persons with brain injury, and persons with spinal cord injury,” 2002 Taylor & Francis Ltd. PMID: 12119077 [Pub Med - indexed for MEDLINE] July 2002. Department of Physical Medicine and Rehabilitation, Virginia Commonwealth University, Medical College of Virginia, Richmond, Virginia 23298-0542, USA. sakolako@hsc.vcu.edu. <http://www.ncddr.org/du/products/saguide/SubAbuse2ndEd.pdf>. Internet; accessed 20 September 2004.



42% of persons with TBI were heavy drinkers. Implications for risk identification, treatment, and future research are discussed.<sup>6</sup>

### SCI Drug Abuse at a Veterans Affairs Medical Center

The target of this study is characteristic of the spinal cord injury trauma patient population in Veterans Affairs Medical Centers nationwide. The data is approximately twelve years old. Yet, the data is still reflective of the current trends and tendencies of the veteran patient population in this study as it related to pre-injury and post-injury instances of drug abuse among Vietnam era veterans.

Substance abuse in the spinal cord injured (SCI) population has been addressed in a few controlled studies. These reports have led to the belief that many SCI patients were illicit drug users prior to their injury and that their drug abuse was a contributing cause of their accidents. One large study determined from answers obtained on a questionnaire that drug abuse, other than alcohol, was prevalent among injured veterans. Our study uses urine toxicology to determine the frequency of drug use and abuse, excluding alcohol, in 72 inpatients and 81 outpatients associated with an urban Veterans Affairs Medical Center. In a blinded experiment, urinary concentrations of opiates, barbiturates, amphetamines, methadone, benzodiazepines, and cocaine were determined with Syva reagents on an Abbott VP. Urinary cannabinoids were determined using Abbott TDX and the FPIA method. The use of illicit (un-prescribed) drugs was surprisingly low ( $\leq 13$  percent) for an urban medical center. Outpatient cannabinoid abuse was significantly more frequent than inpatient usage ( $p < 0.01$ ). Barbiturates were not found in any patient. Benzodiazepines were taken most commonly (29 percent). Since benzodiazepine usage is the direct result of physician prescription, wide-spread usage of this agent is avoidable. Physicians should pay attention to the probable deleterious consequences of benzodiazepine addiction related to

---

<sup>6</sup> S. A. Kolakowsky-Hayner, E. V. Gourley 3rd, J. S. Kreutzer, J. H. Marwitz, D. X. Cifu, and W. O. McKinley, "Pre-injury substance abuse, among persons with brain injury, and persons with spinal cord injury," *Brain Injury*. August 13, 1999. PMID: 10901686 [Pub Med - indexed for MEDLINE] Department of Physical Medicine and Rehabilitation, Virginia Commonwealth University, Medical College of Virginia, Richmond 23298-0542, USA. [http://www.ncddr.org/du/products/saguide/Sub Abuse2ndEd.pdf](http://www.ncddr.org/du/products/saguide/Sub%20Abuse2ndEd.pdf). Internet; accessed 20 September 2004.

depressive effects on the central nervous system caused by its chronic use.<sup>7</sup>

As a whole, many Vietnam era veterans reflect high incidences of using multiple forms of illegal drugs. Likewise, these patterns of abusive drug behavior are reflected in the spinal cord injury trauma patients as well.

### The Influence of Drug Abuse on Psychosocial Variables

The data in this project includes both psychological and sociological variables that go far beyond the scope and components of this project. However, it is significant to acknowledge this data because it does make references to disability due to pain intensity and implies that psychosocial problem are made more complex, with drug abuse.

**Abstract:** We examined differences in demographic/financial characteristics, burnout, job demands/control/strain and symptoms of depression as measured by GHQ among primary care patients with (n=838) and without pain (n=135). In addition, we examined factors associated with the presence of pain by means of logistic regression analyses among all participants, and inter-relations between demographic/financial/pain/health variables, symptoms of depression, burnout, and disability by means of multivariate regression analyses among pain patients. The patients completed a questionnaire about areas such as job strain and burnout. The design was cross-sectional and data were collected during 15 consecutive days. The univariate analyses showed that pain patients, compared with patients without pain, were more often females, older, divorced, foreign born, had been more often on sick-leave, were more preoccupied with how to make ends meet, and had greater difficulties in raising a reasonable sum of money within a specific period of time. In addition, they had greater levels of depression symptoms, burnout, and job strain. However, the multivariate analyses showed that symptoms of depression and

---

<sup>7</sup> J. L. Rothstein, E. Levy, R. Fecher, S. K. Gordon, and W. A. Bauman, "Drug use and abuse in an urban veteran spinal cord injured population," *Journal of the American Paraplegia Society*. October 15, 1992. Veterans Affairs Medical Center, Spinal Cord Injury Service, Bronx, New York. <http://www.ncddr.org/du/products/saguide/SubAbuse2ndEd.pdf>. 2004 PMID: 1431868 [Pub Med -indexed for MEDLINE]. Internet; accessed 20 September 2004.

burnout were more associated with such variables as sick-leave and divorce than by pain parameters.

The logistic regression revealed that the presence of pain was associated with female gender, sick-leave, and high levels of job strain and mean total burnout. Finally, pain patients had a severe clinical situation in terms of, for example, constant, intense, and prolonged pain, and experienced a high degree of disability due to pain. We corroborated previous findings and may have provided new insights into the experiences of pain patients that may be of importance when considering intervention. Although we pointed to some important factors associated with pain, symptoms of depression and burnout, much of their variation remains to be explained. Thus, further research appears necessary, not least concerning the role of burnout as an antecedent to pain.<sup>8</sup>

The frequency and intensity of episodes of pain in the workplace has serious economic repercussions in the realm of business from an employer's point of view and reflects decreases in productivity and increases in absenteeism among employees.

The practice of medicine has become more scientific in recent centuries and has moved towards more psychologically based treatments. With more emphasis being placed upon the role of central nervous system in the perception of pain, the objective of treatment is to reduce the patient's perception of pain and/or his/her reaction to pain as opposed to identifying and removing the cause of pain. Likewise, spinal cord injury trauma patients have the serious concerns about their experiences of perception of pain that moves many of them to consider illegal drug usage alternatives as a means of seeking levels of comfort attempting to free themselves from episodes of pain.

Dr. Albert Ellis is a Rational Emotive Behavior Therapist. Ellis presents interesting views on behavior that suggest that Rational Emotive Therapy has made some break-

---

<sup>8</sup> Joaquim J. F. Soares, and Beata Jablonska, "Psychosocial experiences among primary care patients with and without musculoskeletal pain," Received 14 August 2002; accepted 11 June 2003. Available online 16 December 2003. Unity of Mental Health, Samhällsmedicin (Department of Public Health Sciences, Division of Social Medicine, Karolinska Institute), Box 175 33, Wollmar, Yxkullsgatan 19, SE-118 91, Stockholm, Sweden. Internet; accessed 20 September.

through(s), in the development of a model that can assist anyone facing the challenges and pitfalls of anger.

Chapter Three of Ellis' book, deals with "the Insanity of Anger," in which he states that at the point of consequence, negative feelings can be divided into two major categories: healthy negative feelings and unhealthy negative feelings. He further states that:

Although no strict or inflexible definition exists for either category, we can simply say that when any Adversity (A) occurs in your life, healthy negative feelings consists of attitudes or approaches that will help you get what you want, and help you deal with what you don't want. They will encourage feelings and behaviors that will help you remain alive and live in reasonably happy and productive manner. It follows, then, that unhealthy negative feelings tend to sabotage or inhibit you from achieving what you desire.<sup>9</sup>

Ellis also postulates that belief systems can be divided into two categories. The author states that:

We may safely assume that all human beings have some rational, self-helping and social-aiding beliefs. Our cooperative interaction with other people strongly testifies to the fact that almost all of us have strong sets of rational beliefs that we use to control and direct our personal and social behavior. If we did not, the human race would have progressed very little during its history. As noted in chapter two, we learn our Rational Beliefs from our elders, and they vary greatly in many respects, from culture to culture.<sup>10</sup>

Ellis states that:

Almost every time something happens to you at A (Activating Event), you respond in one of two ways: rationally or irrationally. Although your response often includes a combination of both modes, you can sometimes affect your actions more by one mode than the other. For instance, you may ignore your Rational Beliefs (RBs) and respond to a situation on a largely rational level. Your

---

<sup>9</sup> Albert Ellis, *Anger: How to Live With and Without It* (New York: Kensington Publishing Corp., 2003), 13.

<sup>10</sup> Ibid., 14.

Irrational Beliefs (IBs) about an event may have, thus, had an extremely strong, “winning” influence.<sup>11</sup>

Ellis suggests that it is possible to use the structure and dynamics of his illustrations, to circumvent uncomfortable and destructive episodes that result from unhealthy encounters of anger. Consider the intent and context of one of his illustrations:

We know that when you feel angry with me at C (Consequence), due to your perception of my behavior at A (Activating Event), in that I “unfairly” withdrew from an important agreement with you. Because of this situation, you may say to yourself something like: “What a bad thing he has done to me. How terrible of him to treat me in such a shabby and inconsiderate manner.” This may seem a rational and reasonable statement. Nonetheless, we can see, on reflection, that although you appear to express only one idea here, you in fact have two ideas, each of which you’d better consider separately.

“What a bad thing he has done to me” (meaning, “He has seriously frustrated my plans, and his actions have greatly inconvenienced me”). The observation that I have done a “bad thing” to you seems accurate.

Second, you tell yourself, “How terrible of him to treat me in such a shoddy and inconsiderate manner.” Here you see what I have done as “terrible,” and you wind up with an Irrational Belief. As we shall see later, this idea of thinking of an action or event as “terrible” or “horrible” is unhealthy and irrational because it may lead you to do a good deal of damage to your goals and happiness.

By allowing you IBs to take precedence over your RB, you do not give sufficient attention to the full reality behind your Activating Experience. Your neglecting to contemplate, in advance, the possible outgrowths of your response at C (Consequence), may make you react self-destructively and can lead to the same kind of problems that we saw with both the free-expression method and the “sit-on-your-anger” approach. Rational Emotive Therapy firmly holds that unless you are aware of your ability to change your Irrational Beliefs, you will have difficult problems in dealing with your anger. REBT also maintains the importance of changing your feelings at C when they are destructive. *It states that if you want to change your feelings and your actions in the quickest, most efficient and effective way, you ‘d better pay attention to changing your Belief System.*

---

<sup>11</sup> Ibid.

At A you are sure that I have treated you unfairly by withdrawing from our agreement.

- At RB, your Rational Belief System, you believe, “I don’t like that, I wish he hadn’t treated me so shabbily.”
- At HC, your Healthy Consequence, you experience feelings of disappointment, displeasure, and discomfort.
- *Rational Beliefs (don’t like) and Healthy Consequences (disappointment)* Yet we find that at UC, your Unhealthy Consequence or disturbed feeling, you are angry at me as well as disappointed with my behavior. You find your anger unmanageable and self-defeating, and therefore unhealthy. Using the REBT method, I help you seek the Irrational Beliefs (IBs) that led to your Unhealthy Consequence (raging at me).
- *Irrational Beliefs and Unhealthy Consequence (anger).*<sup>12</sup>

Dr. Defoore says that: “buried anger just won’t stay down.” He says that, in early childhood, we begin the process of learning to suppress our anger. Parents model before their children the practice of staying under control, always speaking in a calm and quiet voice even when the situation calls for an angry response. The end result is that the children become victims of anger abuse. Subsequently, after many years of suppression, anger abuse surfaces in the lives of distracted and dysfunctional adults. Smoke screens and other forms of suppression become uncovered and displayed as various forms of compulsive behavior along with various forms of substance abuse. The author will present some of these manifestations of unhealthy behavior as they are recorded in Defoore’s discussion of compulsion addictions and other smoke screens.

Without anger, we have to develop other ways of protecting ourselves. If we are not going to stand our ground and express our feelings our only option is to withdraw or create some kind of distraction. Some skills for withdrawal are necessary and healthy, and we will talk about that in a later chapter. Distractions are simply a form of denial.

Compulsion and addictions are great “smoke screens” or distractions from the real issues in our lives. If we get involved

---

<sup>12</sup> Ibid., 14-16.

enough in the addiction or compulsion, our anger gets buried under all the new problems resulting from our unhealthy behavior.

Anger does not go away. We can bury it for a while, but it never stays buried. It's only a matter of time before it shows up in a violent rage, a major illness, depression or suicide. When anger is buried, it always has a victim.

We tend to react to buried anger in one or both of the following two ways:

1. We Get Sick. Depression can result from buried anger, and that reduces the effectiveness of our immune system. Physical illness can result from the depression or from the stress caused by the suppressed emotion. The anger does not get expressed, but it makes its presence known. This is sometimes called *internalized anger* or *self-hatred*, leading to suicidal thoughts or suicidal behavior.

2. We Explode in Fits of Anger. These explosions can range all the way from violent rages to minor temper tantrums. The main point is that we are not in control, and we do things we do not intend to do. We often hurt ourselves and others when our buried anger erupts to the surface. This is the "pressure cooker" syndrome we talked about earlier.

When anger is dealt with in these ways, it always has a victim. Compulsive and addictive behaviors can develop in either of the above scenarios. Keeping feelings inside doesn't feel good. It hurts. Drug and alcohol addiction often results from *self-medicating the pain* which is caused by suppressed emotions.

Rageaholics may use substances or compulsive behaviors to try to control their rage. "I am so relaxed and pleasant when I drink. I only fly into those rages when I'm sober." This statement is from a woman in denial, using alcohol to attempt to control her rage.<sup>13</sup>

Childre and Rozman suggest that we can develop anger habits. Certain kinds of visual and/or verbal stimuli, and/or certain situations can set off persons with *anger habits*, like a pressure firing pin. Unfair treatment, discrimination, a lack of appreciation, frustration, anxiety, insecurity and phobias can become the triggering mechanism. Likewise, misunderstanding, misinterpretations or misperceptions can be the catalyst for the manifestation of anger habits. Childre and Rozman also suggest that, because we are

---

<sup>13</sup> Bill Defoore, *Anger: Deal with it. Heal it. Stop it from killing you* (Deerfield Beach, FL: Health Communications Inc., 1991), 12-13.

unique in make-up, dispositions, metabolisms, sensitivities, and other idiosyncrasies, anger manifest in myriad ways. Nevertheless, Childre and Rozman suggest that anger and its derivatives manifest in two major fashions:

People deal with their frustration, anger and resentment in two main ways: repressing or venting. If you are used to *venting*, you may yell, swear, hit something, smash objects, or pound pillows. If you are used to *repressing* anger, you stuff angry feelings down, don't say anything, and blame yourself. Some people *use both ways* and can be *passive-aggressive*. But neither venting nor repressing transforms the anger. It's still there seething inside.

If you are someone who vents, you may think anger feels good, because of the sense of justification, and the rush of adrenaline and release it gives you, but this is only temporary. When you come down from an *angry high*, you're often more drained and cranky than before your outburst. You may also have to deal with consequences of your anger - smashed objects, other people's feelings, the law - which can drain you even more. People who vent do let off steam, but *venting* only keeps *reinforcing the habit of anger*.

If you are someone who represses anger, you have a fire going on down in your body all the time. The fire takes energy to keep burning, and after a while it causes exhaustion, headaches, stomachaches, heart problems, or other illnesses. If you are passive-aggressive, you become sullen or use your anger to intimidate or force others into giving you what you want.

Whether you explode like a volcano or simmer like a slow-cooking stew, the anger stress is still unsolved and can seriously hurt your life - destroying relationships, clouding effective thinking, disrupting work, harming health, and jeopardizing your future. Studies have shown that either *venting* or *suppressing* angry feelings can lead to an increased risk of developing heart disease (Siegman et al. 1998; Gallacher . . . et al. 1999).<sup>14</sup>

In the same way that Tina Turner asks the melodious question: "What's love got to do with it," Childre and Rozman make a parallel inquiry in relation to the organ that symbolizes love, that is, "What's the heart got to do with it?" They declare that the most reliable agency that we possess for transforming a stimulus of anger into a psychosomatic

---

<sup>14</sup> Doc Childre and Deborah Rozman, *Transforming Anger: The HeartMath Solution for Letting Go of Rage, Frustrations, and Irritation* (Oakland, CA: New Harbinger Publications, Inc.), 15-16.



response is the heart. In other words, the central nervous system, especially the heart, can change the body and affect its parts, in response to a habitual response(s) of anger. They elaborate further to say:

In the past decade, researchers have discovered that the heart is a major player in the emotional system. The heart is an information-processing system. There are actually more nerves going from the heart to the brain, than from the brain to the heart (McCraty forthcoming). The heart communicates information to the brain and the rest of the body via four different kinds of pathways: *neurological* (nervous system), *biochemical* (hormones and neurotransmitters), *bio-physical* (blood pressure waves), and *energetic* (electromagnetic fields). All of this information originates within the heart itself.

Your heart's beat-to-beat rhythmic pattern, called *heart rate variability* or HRV, is very sensitive to your changing emotional states. Scientists and health professionals now use HRV analysis as an important measure of many things, including a person's degree of mental and emotional stress. HRV has been found to be an accurate indicator of nervous system aging rate (Umetai et al. 1998) and even a predictor of mortality from all diseases (Tsuji. et al. 1994)

The HRV pattern has a disordered and chaotic rhythm when you experience stressful emotions such as anger, irritation, or frustration. This is called an *incoherent* HRV pattern. . . . Displayed on a computer screen, an incoherent heart rhythm looks rough and jagged—just like you feel inside. By contrast, when you feel positive emotions such as love, care, or appreciation, your heart rhythm pattern becomes more ordered. This is called a *coherent* pattern. Positive emotions create a smooth, coherent, sine-wave-like pattern, and you feel more coherent inside. Your brain functions more efficiently and you think more clearly (Tiller, McCraty, and Atkinson 1996).

A coherent heart rhythm also indicates a state of balance and synchronization between the two branches of your *autonomic nervous system*, the part of your nervous system that controls involuntary processes like heart rate, digestion, and hormonal control. The *sympathetic* branch speeds up your heart rate, and the *parasympathetic* branch slows it down. Positive emotions and coherent heart rhythms cause the parasympathetic and sympathetic nervous systems to operate in harmony. They create a state we call *emotional coherence*. Negative emotions cause these two parts of

the autonomic nervous system, to get out of sync (McCraty. et al. 1995). This creates emotional incoherence.<sup>15</sup>

### **The CPE and Counseling Descriptions, Discussions and Teachings on Anger**

#### **Anger -**

Anger is a passion or emotion directed towards one who inflicts a real or supposed wrong. Ire, wrath, displeasure, resentment, indignation and fury are its common synonyms. Although generally considered undesirable, anger is morally neither positive nor negative in and of itself. Its manifestations determine its constructive or destructive impact, and hence its ethical value.

#### **Hostility –**

Hostility, from which anger is to be distinguished, is a state of antagonism, or animosity toward someone or something. A hostile state usually means opposition to, ill will toward, or destructive intentions with regard to its object. Hostility is synonymous with unfriendliness, animosity and warfare. Unlike anger, hostility implies a negative orientation toward another.

The capacity of anger is a basic human endowment. *Anger* is aroused by a sensory perception plus *an interpretation of the perception* (thoughts which explain or “translate” the perception of the individual). Anger, like all emotions not based on physical stimuli, is thus “born” by an individual’s thoughts; it is in part *a product of interpretation* and thus is always meaningful in some way. Contrary to popular belief, anger (or any other emotion) is not automatically “caused” by someone or some event, but is the result of an individual’s perception and interpretation of a given situation. Not all anger is destructive (unlike hostility which intends to be destructive). The purpose in anger may be a redemptive or a destructive end. Its effect depends on the particular manner employed to convey the emotion. Anger and hostility exhibit many forms and manifestations which are deeply conditioned by culture. Some cultures model constructive and therapeutic ways to channel anger; others evidence destructive forms. For most individuals, it is their families that have the greatest impact on the learning(s) of anger. Anger is generally interpreted as a dangerous emotion in Western culture; thus, most persons learn early to evade, ignore or camouflage it, or to express the feeling with an accompanying moral justification (e.g., “I have good reason to be angry, a right to be angry”).

---

<sup>15</sup> Ibid., 20-22.

Students of human behavior confirm that all individuals experience anger, and that the proper managing of this emotion entails an awareness of its presence and the learning of constructive channels for its expression. Failure to live responsibly with anger can result in costly forms of psychopathology, as seen, for example, in the common unhealthy manifestations of “disguised” anger in the American culture - depression, explosive physical behavior, intimidation, numbness, and alienation.<sup>16</sup>

#### Anger in the Bible:

The destructive and redemptive aspects of anger are evident in both Old and New Testaments. In the OT one recalls the hostility of Cain toward his brother (Genesis 4:6-8), the anger of Joseph's brother toward him in Genesis 37-50, and God's own anger with Moses (Exodus 4:14), the whole people of Israel (Numbers 25:3), and the land (Deuteronomy 29:27), Gideon (Judges 6:39), David (II Samuel 12), and others. The bible treats anger as a natural emotion and does not automatically condemn or approve of it. Each situation is described in its setting; anger is judged on the basis of who experienced it, for what cause, and how it was manifested. People in the Bible are described in human candor, and every emotion is reflected. On the whole, the writers of the OT do not moralize about the virtues and vices of anger. The Book of Proverbs is an exception, yet even in that compendium, the main trait extolled is “slowness to anger,” which is regarded as a characteristic of God (16:32; 19:11). The early view of God's anger as apparently temperamental (e.g., Genesis 18:25) seems gradually to have been modified toward a more mature understanding of a Lord of love whose “anger” is but for a moment, and whose “favor is for a lifetime” (Psalm 30:5).

The NT reflects an understanding of the redemptive possibilities of anger. Incarnation is a manifestation of how God deals with anger in human relationships. Jesus expressed anger in various occasions serving as a model of redemptive anger by demonstrating “concern” for individuals, as in his sorrowful anger over “hardness of heart” (Mark 3:5) and his rebuke of the Pharisees for using religious rules as a weapon against human beings (Matthew 23:13-39). He also employed anger as an expression of “care” when confronting individuals with truth so that they would take redemptive steps for themselves (Matthew 16:23; cf. John 8:31-59).

The apostolic church may not have fared as well in making anger redemptive. Paul's letter shows that early Christians

---

<sup>16</sup> Rodney J. Hunter, H. Newton Maloney, Liston O. Mills, and John Patton, *Dictionary of Pastoral Care and Counseling* (Nashville, TN: Abingdon Press, 1990), 38-39.

struggled with deeply felt differences which sometimes caused serious divisions and became destructive of young fellowships. We may conjecture that these struggles included their share of anger. Presumably, apostolic warnings to put away anger were not given without reason (Ephesians 4:31; Colossians 3:8), even though the writer of Ephesians, citing Jesus (4:26) clearly believed that anger is not sinful in itself ("Be angry and sin not"), even if it can become so if not dealt with in a timely fashion ("Do not let the sun go down on your anger"). Given the amount of dissension in the Corinthian Church and perhaps elsewhere, it is easy to suppose that the first Christian congregation, like so many since who have experienced tension and conflict, failed to understand and implement the positive possibilities for a deeper more trusting common life when anger is dealt with honestly and directly. For it is certain that if real conflict and anger are ignored, major problems—mistrust, misperception, suspicion and alienation—will develop.

#### Assumptions about Anger

Three misconceptions govern an inadequate management of anger by religious people: (1) the erroneous belief that all anger is sinful (and that this is the Bible's teaching); (2) the belief that angry feelings are best managed by being camouflaged or ignored; and (3) the belief—really the illusion—that the unpleasant, or painful feelings such as anger, if ignored will vanish and not continue to influence relationships.

Three corresponding points with regard to anger and its consequences therefore need to be emphasized. (1) Scriptures agree with modern psychological studies, in affirming that anger, though having destructive potential, also has positive and redemptive contributions to offer human relationships. (2) The right acknowledgement and expression of anger assists in deepening and developing social relationships; proper attention to anger can facilitate clarity of relationships and intensify commitments of care and love. (3) Unresolved or unexamined anger interferes with the effective exercise of relationships and produces confusion, misunderstanding, and alienation. Studies performed in four different churches with more than two hundred individuals, for instance, disclosed the fact that harbored anger was a primary reason for unresolved feelings, isolation among persons, and ineffective subsequent action in healing or reconciling efforts (Bagby, 1979).

#### Pastoral Response to Anger: General Principles:

Stewards of anger should first examine their own characteristic manner of handling hostility and anger. Clergy and other counselors

dealing with anger, tend to handle the emotion according to their learned background. Consequently, in a minister has grown up believing that all anger is sin, he or she will usually have no inclination to explore the emotion with angry persons. Pastors and pastoral therapists will only facilitate its exploration if they, themselves, have examined and understood the anger in their own lives. This requires at least two operations:

First, one must discover learned attitudes about anger and its place in one's own life. Counselors need to examine and understand the anger in their own life history and their established patterns of handling animosity, especially including any destructive patterns. CPE is a particularly important resource for this. It is designed partly, to assist participants in discovering, accepting, and responsibly handling their feelings in ministry, and anger is often a central emotion in such training experiences. The CPE approach typically combines concerns for the outward manifestations and control of anger in relation to professional role and pastoral need, with a depth-oriented examination of one's emotional history and character and the dynamic structure of one's interpersonal relationships. Thus, the issue of management and control of this powerful emotion is related to the fundamental question about the self and relationships. There are, however, also programs for clergy that concentrate mainly on methods of cognitively and behaviorally understanding, controlling, and effectively managing anger. Conflict management experts, for example, are available to lead seminars at which church leadership can learn more effective means of channeling anger, and there are many centers and learning institutions available which assist individuals in self-understanding through psychological testing and helpful self-clarification sessions.

Second, counselors must develop redemptive avenues to channel anger. Persons responsible for anger management, such as persons in positions of leadership, should work at modeling healthy and constructive ways of displaying anger. Pastoral counselors can further enrich this modeling function through distinctively therapeutic insights and responses to anger. These tend to bring out its potential for deepened self-understanding, more emotionally rich and rewarding relationships, and personal growth. Such counselors can also become trusted examples to parishioners who often struggle with therapeutically inadequate role models in the management of anger. Responsible use of anger includes an understanding and expression of the emotion in ways that allow for continuing communication which preserves the respect and integrity of the person to whom anger is being directed and maintains or enhances relationships.

### Inadequate and Pathological Forms of Anger:

**Depression:** Much of what people call depression is believed to be anger turned upon one's self. Persons who grow up in an atmosphere that discourages open expression of anger often end up internalizing their feelings. The expression "swallow one's feelings" is descriptive. Unfortunately, such learned behavior, rather than alleviating the situation, can cause a variety of physical symptoms (ulcers, diarrhea, tension headaches, and melancholic distress) and emotional pain because such persons are punishing themselves on an ongoing basis. They are surprised if someone suggests that any negative or strong feelings may be at work within them, and usually resist suggestions that anger may be a factor in their physical or emotional distress.

Counselors can assist the angry or depressed person by gently providing an atmosphere in which anger can be voiced and received. The first step in making such anger redemptive is to acknowledge its presence, and the therapist or caring person must stimulate insight to help the person discover the negative emotions stacked up inside. Avenues for responsible venting of feeling must also be provided. A supportive counseling atmosphere, a trusted group (in and out of the congregation), and selective friends who will listen with sensitivity may all provide safe and helpful outlets for expressions of pent-up anger and aggression. Physical exercise and active participation in sports are also effective tools to ventilate and sublimate suppressed anger in the angry-depressed.

### Physical and Verbal Outbursts:

Some individuals have learned to handle their anger impulsively and outwardly, by "expelling" it. Such persons have usually grown up in an atmosphere where disputes were settled by "letting it all hang out" rather than by practicing impulse control through good communication and mutual problem solving. Persons who have emotional outbursts often frighten others, abuse them emotionally and physically and are seldom aware of the manipulative intent of their actions, or the impact or severity of their behavior.

Such persons usually expect people to reject them. They have learned over a long period of time that rejection is likely, and they set themselves up to cause it. Some individuals who practice this inadequate means expressing anger do so as a cover for their own feelings of inadequacy or anxiety in certain circumstances.

A counselor is aware of these dynamics can assist the angry/outspoken persons, at one level, by making them aware of the effect of their explosive manner on others. At a deeper level, however, the counselor offers such persons a qualitatively new kind

of relationship, one in which the angry/outspoken individual is unable to alienate and manipulate the counselor and gain the hidden neurotic gratification that she or he has learned to expect from angry outbursts. Resisting all such ploys, the healing individual surprises the angry/outspoken person with acceptance and care, and steadily teaches him or her how to moderate expressions of anger and how to communicate it more effectively.

#### Fear of Anger:

Some people have been taught to cower under the pressure of anger. Persons who become afraid of anger most often are frightened by their own feelings and those of others. They flinch under verbal abuse, often cry, and withdraw into themselves for protection. Such inadequate responses to anger are multiplied by their fear of their own feelings, especially of anger.

The presenting signals for such unhealthy reactions to anger in others are usually a generalized anxiety (without apparent cause), a forced "meek" disposition, a perception of fear of people and gatherings of people, and a general sense of intimidation. Such persons rarely offer their opinion, certainly not in a public setting, and the whole community loses.

The most effective reversal of fear of anger is a gentle and long-term supportive relationship with someone who will "bring out" the intimidation and assist them to find courage in expressing their fears. One immediate fear is that their feelings, so far suppressed, if released, will overwhelm them and others. The patient reassurance, along with the steady reality that a counselor is not being "overcome" with their anger (at first intense, but soon quite mild if regularly expressed) can encourage this person, who has learned to ask the world for forgiveness for existing, and for the privilege of being "stepped on."

#### The Angry-numb

Some individuals have learned to submerge and anesthetize their feelings by not allowing any outward expression. They have learned "not to feel." Every pastor knows individuals who are physically present in the life of the church, but otherwise immobilized and apathetic. They neither contribute nor participate emotionally, for anger has "coated" their lives with a deadening anesthetic. Their healing can only take place with people who will assist them to understand the role that anger has assumed in their deadlock of feelings. Together with caring and trusted friends, they can begin

the process of uncovering the layers of buried hostility which paralyze and debilitate their performance and freedom.<sup>17</sup>

#### The Angry-Alienated:

These individuals actually withdraw in the face of anger, remain unattached, removing themselves from community and from many relationships. Such persons have found withdrawal a safer way to deal with their animosities, but the ensuing alienation and isolation are a high price to pay to avoid anger. Church rolls abound with the names of individuals who have "withdrawn fellowship" under circumstances of disaffection. The main result of this mismanagement of feelings is that the anger involved is rarely dealt with; it remains as a constant source of isolation and distance in relationships, sometimes for years. A constructive ministry with the angry-withdrawn involves a tender approach and a steadfast initiative. Unable to take initiative themselves, such victims of isolation will usually not respond at first, to care or to interest expressed toward them. Patience and determination to assist them in dealing with their unresolved emotions is a first step toward their full participation in relationships. Direction and support as they explore the nature of their angry wound will also encourage them to evaluate and reconsider their approach to anger.

Constructive exploration of anger will usually include some clarity and evaluation of the motives and reasons for anger. An open, nonjudgmental attitude on a counselor's part always enhances the atmosphere required for honest exploration of strong feelings. A continued communication of respect and appreciation for the person with whom one is dealing is also an essential ingredient in redemptive work with anger and hostility. And perhaps the most important factor in ministry with angry persons is the declared intention that anger will not be used as a means to sever a relationship, but as a shared emotion given in trust which has the potential of deepening the relationship at stake.<sup>18</sup>

#### Anger and Meekness (Moral Theology)

Anger is (a) an emotional agitation aroused by dissatisfaction and leading to an impulse to seek redress; (b) the inordinate inclination to vengeance. Meekness is (a) a habit of patient endurance under provocation; (b) in a pejorative sense, spineless submissiveness.

Anger: Three phases of anger can be noted. Anger arises as a normal response to any of a vast array of untoward events,

---

<sup>17</sup> Ibid., 39-41.

<sup>18</sup> Ibid., 41.



including physical evils like a kick or spiritual evils like unjust treatment. This discontent quickly evokes a psychosomatic agitation which fills the body, and frequently, focuses the whole attention on the offender. Third, anger develops an impulse against the causes of the harm. Usually, if not always, some sort of responsibility is imputed to the immediate or remote cause of the offence.

Scripture indicates instances of good anger. Anger is legitimate when the perception of the evil is accurate, when the excitation is proportionate to the evil, and when the impulse is directed toward correcting the ill. Scripture also warns against anger, and - influenced by Stoicism - much of the Christian tradition has judged that morally good anger seldom occurs. The way anger so quickly absorbs a person, distorts perspective, rages out of control, and leads to violent actions, has made all anger, suspect. Reason, the imagination, and the heart turns away from their proper functions and become subservient to anger's fury. The moral issue is not merely, how one acts out an emotion, but also the justifiability of the emotion itself. Anger often is misdirected, for example, when it strikes out against one person because of harms received from another, say, from a parent. Like other emotions, anger can expand beyond its original cause. It can turn into a simmering rancor or into a thirst for vengeance. Anger has been included among the seven capital or deadly sins because it often inspires a host of sins.

Meekness: Since anger can be legitimate, meekness is not exactly its moral opposite. Rather meekness, after the example of Jesus, is a patient endurance of both justifiable and unjustifiable harms. According to Paul, meekness is a gift of the Holy Spirit. Toward God, meekness represents a docility which does not revolt against God's sometimes burdensome will. In human interaction, meekness means a self-possession which modulates excessive reactions. The meek restrain, if not altogether suppress, anger's impulse to seek redress. Further, both rancor and a continued desire for revenge are absent in the meek. Meekness can be a deficiency if it means mere indolence, paralysis through fear, or absence of normal reactions to evil.

Meekness is, in fact, a virtue of strength. The just war tradition is based on the strength of meekness. Patient endurance is necessary for a peaceable society, but it is also—according to the Beatitudes of Jesus' example—part of life of one who adheres to God. Jesus is the model of one who can react with anger, but also with meekness.<sup>19</sup>

---

<sup>19</sup> Ibid.

Finally, within the intent and context of the Holy Bible, anger is not simply an emotion. In the Holy Bible, anger is a spirit that comes forth from God. More specifically, it is referred to as the wrath of God that comes down to Earth from the distant Heavens.

According to the King James Version of the Holy Bible, there are 207 references to the “wrath” of God: 160 in the Old Testament Scriptures, and 47 in the New Testament Scriptures. Also, according to the King James Version of the Holy Bible, there are 27 references to the “anger” of God: 22 in the Old Testament Scriptures, and 5 in the New Testament Scriptures. Furthermore, according to the King James Version of the Holy Bible, there are 18 references to the “rage”: 17 in the Old Testament Scriptures, and 1 in the New Testament Scriptures.

Below is a series of Old Testament words, and their cognates and/or derivatives for: “wrath” or “anger.” In all instances, the intent and context of these Hebrew/Aramaic words reflect consistency with the contemporary research associated with the autonomic nervous system, sympathetic nervous system and the parasympathetic nervous system.

OT:639 'Aph (af); from OT:599; properly, “the nose or nostril”; hence, *the face*, and occasionally a person; also (*from the rapid breathing in passion*) ire: KJV—*anger* (-gry), + before, countenance, face, + forebearing, forehead, + [long-] suffering, nose, nostril, snout, X worthy, *wrath*.

OT:599 'Anaph (aw-naf); a primitive root; *to breathe hard*, i.e., *be enraged*: KJV—*be angry* (*displeased*). <sup>2</sup>'Anaph — *to be angry, to be displeased, to breathe hard*; a) (Qal) *to be angry* (used of God); b) (Hithpael) *to be angry* (always of God).

OT:5678 'Ebrah (eb-raw'); feminine of OT:5676; *an outburst of passion*: KJV—*anger, rage, wrath*.

OT:5676 'Eber (ay'-ber); from OT:5674; properly, *a region across*; but used only adverbially (with or without a preposition) *on the opposite side* (especially of the Jordan; usually meaning the east): KJV—X against, beyond, by, X from, *over*, passage, quarter, (other, this) side, straight.

OT:5674 'Abar (aw-bar'); a primitive root; *to cross over*, used very widely of any transition (literal or figurative; transitive, intransitive, intensive, causative); specifically, *to cover (in copulation)*: KJV—alienate, alter, X at all, beyond, *bring (over, through)*, *carry over*, (over-) come (on, over), conduct (over), convey over, current, deliver, do away, enter, escape, fail, gender, get over, (make) go (away, beyond, by, forth, his way, in, on, over, through), have away (more), lay, meddle, overrun, make partition, (cause to, give, make to, over) pass (-age, along, away, beyond, by, -enger, on, out, over, through), (cause to, make) + proclaim (-amation), perish, *provoke to anger*, put away, *rage*, + raiser of taxes, remove, send over, set apart, + shave, cause to (make) sound, X speedily, X sweet smelling, take (away), (make to) transgress (-or), translate, turn away, [way-] faring man, *be wrath*.

OT:7265 Regaz (Aramaic) (reg-az'); corresponding to OT:7264: KJV—*provoke unto wrath*. Regaz (Aramaic) — (Aphel) *to rage, to enrage*. OT:7264 Ragaz (raw-gaz'); a primitive root; to quiver (with any violent emotion, especially *anger or fear*): KJV—*be afraid*, stand in awe, disquiet, fall out, fret, move, provoke, quake, *rage*, shake, tremble, trouble, *be wroth*.<sup>20</sup>

Below is a series of New Testament words and their cognates and/or derivatives for: “wrath” or “anger.” In all instances, the intent and context of these Greek words reflect consistency with the contemporary research associated with the autonomic nervous system, sympathetic nervous system and the parasympathetic nervous system.

NT:3709 Orge (or-gay'); from NT:3713; properly, *desire (as a reaching forth or excitement of the mind)*, i.e., (by analogy,) *violent passion* (ire, or [justifiable] abhorrence); by implication punishment: KJV—*anger*, indignation, vengeance, *wrath*.

NT:3713 Oregomai (or-eg'-om-ahee); middle voice of apparently a prolonged form of an obsolete primary [compare NT:3735]; to stretch oneself, i.e. reach out after (long for): KJV—covet after, desire.

NT:3735 Oros (or'-os); probably from an obsolete oro (to rise or “rear”; perhaps akin to NT: 142; compare NT:3733); a mountain (as lifting itself above the plain): KJV—hill, mount (-ain).

---

<sup>20</sup> *New Exhaustive Strong's Numbers and Concordance with Expanded Greek-Hebrew Dictionary* [CD-ROM] (Biblesoft and International Bible Translators, Inc., 1994).

NT:2372 Thumos (thoo-mos'); from NT:2380;/x355/ow (*as if breathing hard*): KJV—fierceness, indignation, *wrath*. Compare NT:5590. NT:2380 Thuo (thoo'-o); a primary verb; properly, *to rush (breathe hard, blow, smoke)*, i.e. (by implication) to sacrifice (properly, by fire, but genitive case); by extension to immolate (slaughter for any purpose): KJV—kill, (do) sacrifice, slay.

NT:3949 Parorgizo (par-org-id'-zo); from NT:3844 and NT:3710; *to anger alongside*, i.e., *enrage*: KJV—*anger, provoke to wrath*.

NT:3844 Para (par-ah'); a primary preposition; properly, *near*; i.e. (with genitive case) *from beside* (literally or figuratively), (with dative case) *at (or in) the vicinity of* (objectively or subjectively), (with accusative case) *to the proximity with* (local [especially beyond or opposed to] or causal [on account of]): KJV—above, against, among, at, before, by, contrary to, X friend, from, + give [such things as they], + that [she] had, X his, in, more than, nigh unto, (out) of, past, save, side . . . by, in the sight of, than, [therefore-], with. In compounds it retains the same variety of application.

NT:3710 Orgizo (or-gid'-zo); from NT:3709; *to provoke or enrage*, i.e. (passively) become exasperated: KJV—*be angry (wroth)*.<sup>21</sup>

According to King James Version, Romans 1:16-32 says the following:

(16) For I am not ashamed of the gospel of Christ: for it is the power of God unto salvation to every one that believeth; to the Jew first, and also to the Greek. (17) For therein is the righteousness of God revealed from faith to faith: as it is written: The just shall live by faith. (18) For the wrath of God is revealed from heaven against all ungodliness and unrighteousness of men, who hold the truth in unrighteousness; (19) Because that which may be known of God is manifest in them; for God hath showed it unto them. (20) For the invisible things of him from the creation of the world are clearly seen, being understood by the things that are made, even his eternal power and Godhead; so that they are without excuse: (21) Because that, when they knew God, they glorified him not as God, neither were thankful; but became vain in their imaginations, and their foolish heart was darkened. (22) Professing themselves to be wise, they became fools, (23) And changed the glory of the uncorruptible God into an image made like to corruptible man, and to birds, and four-footed beasts, and creeping things. (24) Wherefore God also gave them up to uncleanness through the lusts of their own hearts, to dishonor their own bodies between themselves: (25) Who

---

<sup>21</sup> Ibid.

changed the truth of God into a lie, and worshipped and served the creature more than the Creator, who is blessed for ever. Amen. (26) For this cause God gave them up unto vile affections: for even their women did change the natural use into that which is against nature: (27) And likewise also the men, leaving the natural use of the woman, burned in their lust one toward another; men with men working that which is unseemly, and receiving in themselves that recompense of their error which was meet. (28) And even as they did not like to retain God in their knowledge, God gave them over to a reprobate mind, to do those things which are not convenient; (29) Being filled with all unrighteousness, fornication, wickedness, covetousness, maliciousness; full of envy, murder, debate, deceit, malignity; whisperers, (30) Backbiters, haters of God, despiteful, proud, boasters, inventors of evil things, disobedient to parents, (31) Without understanding, covenant-breakers, without natural affection, implacable, unmerciful: (32) Who knowing the judgment of God, that they which commit such things are worthy of death, not only do the same, but have pleasure in them that do them.

It is clearly stated, and elaborated upon. In verse 18 it says: "For the wrath of God is revealed from Heaven." In other words, the wrath of God is not from the Earth's surface or the pits of Sheol/Hell, but from "out of the Heavens."

## **CHAPTER THREE**

### **THEORETICAL FOUNDATION**

#### **Theological Foundation Of Support For A Theology Of Pastoral Care**

For the author, a Theological Foundation that supports a Theology of Pastoral Care must contain at least four elements in order to attempt to treat the syndrome of anger pain and illegal drug abuse: (a) The existence of the estate of the Godhead which includes the acknowledgment of the sovereignty of Father God and His appointment of His first and only begotten Son God as His Proxy/Mediator/Executive to all subsequently appearing creatures and/or instances of creation, per John 3:16-21; John 1:1-18 and Hebrews 1:1-14. Only the love of God through the agency of the Godhead can give us the wherewithal to attempt to address the many variables of the syndrome of anger, pain, and illegal drug abuse in each spinal cord injury trauma patient's experience. Because of their vast differences in physiology, psychology, sociology, temperament, and metabolism, spinal cord injury trauma patients need to establish a theological foundation to confront the complexities of a syndrome of anger pain and illegal drug usage.

John 3:16-21 (KJV) says the following:

(16) For God so loved the world that he gave his only begotten Son, that whosoever believeth in him should not perish, but have everlasting life. (17) For God sent not his Son into the world to condemn the world; but that the world through him might be saved. (18) He that believeth on him is not condemned: but he that believeth not is condemned already, because he hath not believed in the name of the only begotten Son of God. (19) And this is the

condemnation, that light is come into the world, and men loved darkness rather than light, because their deeds were evil. (20) For every one that does evil hates the light, neither cometh to the light, lest his deeds should be reprov'd. (21) But he that doeth truth cometh to the light, that his deeds may be made manifest, that they are wrought in God.

John 1:1-18 (KJV) says the following:

(1) In the beginning was the Word, and the Word was with God, and the Word was God. (2) The same was in the beginning with God. (3) All things were made by him; and without him was not any thing made that was made. (4) In him was life; and the life was the light of men. (5) And the light shined in darkness; and the darkness comprehended it not. (6) There was a man sent from God, whose name was John. (7) The same came for a witness, to bear witness of the Light that all men through him might believe. (8) He was not that Light, but was sent to bear witness of that Light. (9) That was the true Light, which lights every man that comes into the world. (10) He was in the world, and the world was made by him, and the world knew him not. (11) He came unto his own, and his own received him not. (12) But as many as received him, to them gave he power to become the sons of God, even to them that believe on his name: (13) Which were born, not of blood, nor of the will of the flesh, nor of the will of man, but of God. (14) And the Word was made flesh, and dwelt among us, (and we beheld his glory, the glory as of the only begotten of the Father,) full of grace and truth. (15) John bare witness of him, and cried, saying, this was He of whom I spoke, He that comes after me is preferred before me: for he was before me. (16) And of his fullness have all we received, and grace for grace. (17) For the law was given by Moses, but grace and truth came by Jesus Christ. (18) No man hath seen God at any time; the only begotten Son, which is in the bosom of the Father, he has declared him.

Hebrews 1:1-14 (KJV) says the following:

(1) God, who at sundry times and in divers manners spake in time past unto the fathers by the prophets, (2) Hath in these last days spoken unto us by his Son, whom he hath appointed heir of all things, by whom also he made the worlds; (3) Who being the brightness of his glory, and the express image of his person, and upholding all things by the word of his power, when he had by himself purged our sins, sat down on the right hand of the Majesty on high; (4) Being made so much better than the angels, as he hath by inheritance obtained a more excellent name than they. (5) For unto which of the angels said he at any time, Thou art my Son, this

day have I begotten thee? And again, I will be to him a Father, and he shall be to me a Son? (6) And again, when he bringeth in the first-begotten into the world, he saith, And let all the angels of God worship him. (7) And of the angels he saith, Who maketh his angels spirits, and his ministers a flame of fire. (8) But unto the Son he saith, Thy throne, O God, is for ever and ever: a sceptre of righteousness is the sceptre of thy kingdom. (9) Thou hast loved righteousness, and hated iniquity; therefore God, even thy God, hath anointed thee with the oil of gladness above thy fellows. (10) And, Thou, Lord, in the beginning hast laid the foundation of the earth; and the heavens are the works of thine hands: (11) They shall perish; but thou remainest; and they all shall wax old as doth a garment; (12) And as a vesture shalt thou fold them up, and they shall be changed: but thou art the same, and thy years shall not fail. (13) But to which of the angels said he at any time, Sit on my right hand, until I make thine enemies thy footstool? (14) Are they not all ministering spirits, sent forth to minister for them who shall be heirs of salvation?

(b) The author must acknowledge, accept, and respect, the individual differences in every person, (c) The author must acknowledge both his strengths and weaknesses and minister to other persons out of his learning experiences and/or out of his healed wounds, (d) The author must acknowledge his unique role as a man of faith, serving as a co-participating caregiver within the interdisciplinary hospital community of medical, nursing, psychological and social scientists and in conjunction with occupational and physical rehabilitation therapists.

The first foundational element in the author's theology of pastoral care must be the acknowledgement and acceptance of the sovereignty of Father God as the Supreme Being who loves us. Subsequently, the Father appointed His first and only begotten Son to represent Him, and then sent Him forth to rule/reign over all of creation. When Father God sent His Son forth from His face(s), this was the beginning of the Son's assignment as the Creator. His Hebrew proper name was Jehovah. Subsequently, as Emmanuel, when the Father sent Him forth in His incarnation, His proper name was Jehoshua/Joshua/Jesus



(i.e., Jehovah, a Savior). Who the first and only begotten Son of God is, in His appointed sovereignty, and the author's concept of Him as the Sovereign Executive of the Office, Authority and Power of God His Father, are probably not always congruent, on a day-to-day basis, because the author's understanding of Him is expanding and evolving, even as we speak. The author has his own ideas about what a good God should be in his life and what He should do for him in the midst of his circumstances. Nevertheless, the author will not try to reinterpret or compromise the Holy Scriptures or the word of God for the purpose of supporting or validating his own ideas, personal preferences, or idiosyncrasies. Instead, the author will repent and ask forgiveness of his sins, in faith turning towards Father God, pleading the blood of Jesus Christ. In the name of Jesus, the author willfully acknowledges the relevance of the images, likenesses, models, rigors and destiny of the descendants of the estate of Adam within the intent and context of the Judeo-Christian Scriptures as the bases and boundaries for who he is, and who he is to become as a man, a Pastor and/or a Chaplain.

To that end, the author has been reinforced in understanding Isaiah 55:8-9 (KJV) and accepts it as an accurate statement for himself:

For my thoughts are not your thoughts, neither are your ways my ways, says the LORD. For as the heavens are higher than the earth, so are my ways higher than your ways, and my thoughts than your thoughts.

The author knows that God loves him, cares for him, and that he has a definite plan for his life. The author surrenders to His will for him and for his life. The author is in pursuit of his destiny in God and his highest good as a redeemed son of God. The author has concluded that God gives him what He thinks and knows is good and right for him, as He continues to mold him and shape him in accordance with His design for his life. In spite

of the pain of failure, disappointment, and rejection, the author is determined to be a willfully subservient Christian man, Pastor and/or Chaplain, in the service of the Lord. The author is complete in Jesus Christ, for the fullness of the Godhead dwells in him as a saint, a son of God, and a disciple/priest, within the body of Christ.

Colossians 2:7-19 (KJV) says the following:

(7) Rooted and built up in him, and established in the faith, as ye have been taught, abounding therein with thanksgiving. (8) Beware lest any man spoil you through philosophy and vain deceit, after the tradition of men, after the rudiments of the world, and not after Christ. (9) For in him dwells all the fullness of the Godhead bodily. (10) And ye are complete in him, which is the head of all principality and power: (11) In whom also ye are circumcised with the circumcision made without hands, in putting off the body of the sins of the flesh by the circumcision of Christ: (12) Buried with him in baptism, wherein also ye are risen with him through the faith of the operation of God, who hath raised him from the dead. (13) And you, being dead in your sins and the un-circumcision of your flesh, hath he quickened together with him, having forgiven you all trespasses; (14) Blotting out the handwriting of ordinances that was against us, which was contrary to us, and took it out of the way, nailing it to his cross; (15) And having spoiled principalities and powers, he made a show of them openly, triumphing over them in it. (16) Let no man therefore judge you in meat, or in drink, or in respect of an holy day, or of the new moon, or of the Sabbath days: (17) Which are a shadow of things to come; but the body is of Christ. (18) Let no man beguile you of your reward in a voluntary humility and worshipping of angels, intruding into those things which he hath not seen, vainly puffed up by his fleshly mind, (19) And not holding the Head, from which all the body by joints and bands having nourishment ministered, and knit together, increases with the increase of God.

Therefore, in the author's theology of pastoral care, Father God is sovereign and He loves us. He sent His first and only begotten Son God to reconcile the author into a holy and righteous relationship with Him. Therefore, as a willfully subservient disciple/priest in Jesus Christ, the author is also partaking of His grace in redemption as an intentional participant in the praise, worship and service of our Sovereign Father God.

The second foundational element in the author's theology of pastoral care is the acknowledgement, acceptance and respect for individual differences in people. In David Kiersey's book, *Please Understand Me II*, the author has found one of the best rationales for working at the task of identifying individual differences in people and forsaking the stifling generalizations of bigotry, intolerance, prejudice and narrow-mindedness. It is called "Different Drummers," and this is a direct quote:

If you do not want what I want, please try not to tell me that my want is wrong; or if my beliefs are different from yours; at least pause before you set out to correct them. Or if my emotion seems less or more intense than yours, given the same circumstances, try not to ask me to feel other than I do (or to feel like you do). Or if I act, or fail to act, in the manner of your design for action, please let me be. I do not, for the moment at least, ask you to understand me. That will come only when you are willing to give up trying to change me into a copy of you. If you will allow me any of my own wants, or emotions, or beliefs, or actions, then you open yourself to the possibility that some day these ways of mine might not seem so wrong, and might finally appear as right—for me. To put up with me is the first step to understanding me. Not that you embrace my ways as right for you, but that you are no longer irritated or disappointed with me for my seeming waywardness (i.e., straying away from becoming like you). And one day, perhaps, in trying to understand me, you might come to prize my differences, and far from seeking to change me, might preserve and even cherish those differences. I may be your spouse, your parent, your offspring, your friend or your colleague. But whatever our relation (-ship), this I know: You and I are fundamentally different and each of us has to march to his/her own drummer.<sup>1</sup>

The author includes as a theological backdrop to the aforementioned quotation, Romans 14:1-23, with special emphasis on verse 5b and 7-13:

(1) Him that is weak in the faith receive ye, but not to doubtful disputations. (2) For one believeth that he may eat all things: another, who is weak, eats herbs. (3) Let not him that eats despise him that eats not; and let not him which eats not judge him that eats: for God hath received him. (4) Who art thou that judges

---

<sup>1</sup> David Kiersey, *Please Understand Me II* (Del Mar, CA: Prometheus Nemesis Book Company, 1998), 1.

another man's servant? To his own master he stands or falls. Yea, he shall be held up: for God is able to make him stand. (5) One man esteems one day above another: another esteems every day alike. *Let every man be fully persuaded in his own mind.* (6) He that regards the day, regards it unto the Lord; and he that regards not the day, to the Lord he doth not regard it. He that eats, eats to the Lord, for he gives God thanks; and he that eats not, to the Lord he eats not, and gives God thanks. (7) For none of us lives to himself, and no man dies to himself. (8) For whether we live, we live unto the Lord; and whether we die, we die unto the Lord: whether we live therefore, or die, we are the Lord's. (9) For to this end Christ both died, and rose, and revived, that he might be Lord both of the dead and living. (10) But why dost thou judge thy brother? Or why dost thou set at nought thy brother? *For we shall all stand before the judgment seat of Christ.* (11) For it is written, as I live, said the Lord, every knee shall bow to me, and every tongue shall confess to God. (12) So then every one of us shall give account of himself to God. (13) Let us not therefore judge one another any more: but judge this rather, that no man put a stumbling-block or an occasion to fall in his brother's way. (14) I know, and am persuaded by the Lord Jesus, that there is nothing unclean of itself: but to him that esteems any thing to be unclean, to him it is unclean. (15) But if thy brother be grieved with thy meat, now walks thou not charitably. Destroy not him with thy meat, for whom Christ died. (16) Let not then your good be evil spoken of: (17) For the kingdom of God is not meat and drink; but righteousness, and peace, and joy in the Holy Ghost. (18) For he that in these things serves Christ is acceptable to God, and approved of men. (19) Let us therefore follow after the things which make for peace, and things wherewith one may edify another. (20) For meat destroy not the work of God. All things indeed are pure; but it is evil for that man who eats with offence. (21) It is good neither to eat flesh, nor to drink wine, nor any thing whereby thy brother stumbles, or is offended, or is made weak. (22) Hast thou faith? Have it to thyself before God. Happy is he that condemns not himself in that thing which he allows. (23) And he that doubts is damned if he eats, because he eats not of faith: for whatsoever is not of faith is sin.

Particularly, Romans 14:5b says: "Let every man be fully persuaded, convinced and/or decided, in his/her own mind." Therefore, by acknowledging, accepting and respecting individual differences of other people, the author will and must resist the urge to attempt to shape them (i.e., others) in his image and after his likeness. Hopefully, God

will allow the author to be able to see them for who they are, who God wants them to be, or who they are trying to become, according to their own designs.

In his experiences as a Pastor and Chaplain, his observations suggest that the greatest catalysts for causing people to abandon habitual behaviors, stayed attitudes and the return to familiar environments and/or circumstances are varying episodes and forms of pain, frustration and suffering. We cannot make permanent changes in people using principles of psychological theories, and/or techniques of behavioral science. Nevertheless, unpleasant and uncomfortable circumstances have proven to possess considerable persuasive powers as agents for meaningful change. As a Pastor and/or Chaplain, the author has come to know that most of us will not let go of anything familiar until the pain of maintenance becomes unbearable and/or unmanageable. The ground must literally crumble under our feet before we will consider any form of change. The hospital environment is full of people who have experienced many painful, unbearable tragedies in their lives. The loss of limbs, body parts, independence, mobility and/or liberty, force many of us to embrace unlikely, inconvenient, uncomfortable, and cumbersome ways of negotiating the everyday things of that happen in our lives. Nothing can be taken for granted anymore. Even the simplest tasks require the assistance of others or the deployment of some kind of auxiliary machinery or supplementary apparatus, like a wheelchair, crutches, scooters, or some form of implants. Hopefully, the author will be able to encourage some of them to consider looking at these painful incidents and/or tragedies as God taking the initiative to destroy their dysfunctional dreams of low expectations. God does not change us against our wills, but he will shatter and scatter our broken dreams and create an atmosphere that will cause us to have to consider the relevance and/or practicality of alternatives. For those who love Him, there is good news.

God will shatter our dreams in such a way, that it will help us to continue to seek His face so that we can begin to approach the joy of experiencing our highest dream.

In the third foundational element of his theology of pastoral care, the author must get to know who he is, both in his strengths and weaknesses and minister to others out of his learning experiences, and out of his healed wounds. Being a Christian does not mean that the author is perfect. The author is nobody's role model because he does have a past with some unresolved issues. Some parts of his past are filled with too many impromptu experiences and disappointing episodes. Being a Christian does not mean that the author is perfect. It means that he is forgiven by the Sovereign Father God, through the Lord Jesus Christ. In some instances, the author succeeded and other times he failed. On a daily basis, he is trying to live life fully and completely, perceiving each day as a gift from God, one day at a time.

Living life as a Christian Pastor and/or Chaplain is like playing baseball in the big leagues. You may have been a .500 hitter yesterday, but the pitcher in today's game did not read your press clippings in the sports page. He does not know how good you are supposed to be. Hopefully you have learned critical lessons about pitchers, their habits and tendencies from your past experiences in the big leagues. As a seasoned player, the expectation is that past experiences will serve you well in today's game. Remember this; the team cannot win today's game based on yesterday's glowing statistics. The bottom-line is: "what can you do for your team today?"

As a Chaplain, the author is a member of the care-giving team. He must make every effort to minister to patients out of his history of the emotional, psychological and spiritual wounds in his life; hopefully, the ones that are healed. The author is required to willfully enter into every opportunity for ministry with a functional knowledge and

understanding of most of his human vulnerabilities and share them with certain patients as a fellow sufferer who is now an over-comer whenever sharing is deemed appropriate and/or relevant to the issue(s) at hand. Therefore, as a Pastor and/or Chaplain, before the author leaps into the fray against suffering, pain, depression, sadness and sickness, he must put on the whole armor of God, according to the guidance of Ephesians 6:10-18. He must put on the whole armor so that he can stand against the enemies of God and God's people. The Chaplain/Pastor/author must withstand the methodologies of the devil and thereby offend the spiritual host of wickedness to the glory of God the Father in the name of Jesus Christ. Doing ministry as a Chaplain and/or Pastor is different in this contemporary society, in this age of technology, automation and computers. Isolation is one of the most horrible forms of human suffering and the passivity that separation evokes can cause many of us to feel that we are unable to make any meaningful changes in the direction of our lives. The author's understanding of the Judeo-Christian context tells him that we are not alone, not abandoned or forsaken. We do not have to bear these burdens alone. Assistance is available to everyone, especially Christian believers who are the purchased property of our Sovereign Father God. That help is available to anyone who acknowledges and accepts the blessing of salvation in Jesus Christ under the sovereignty of Father God. Therefore, in the author's practice of the ministry of Chaplaincy, he must be willing to minister to others as a concerned and informed caregiver, ministering out of his own healed wounds and out of his learning experiences with a minimum of overt self-disclosure.

In the fourth foundational element of the author's theology of pastoral care, he must acknowledge the gravity of his unique role as a man of faith serving as co-participating caregiver within the interdisciplinary hospital community of medical, nursing,

psychological and social scientists and in conjunction with occupational and physical rehabilitation therapists. To be sure, it can be an overwhelming experience for a man/woman of faith to speak out in favor of supporting the impossible and/or the improbable claims of hope when scientific investigations and critical analyses of medical diagnosis and prognosis speak to the contrary. To that end, the interdisciplinary hospital community can be a hostile and intimidating environment for members of the Chaplaincy. There are some scientific medical professionals who are quite irreverent and disrespectful of anything other than factual assertions or scientific medical data. Their condescending glares and disrespectful demeanors add elements of anxiety, tension and discomfort to the interdisciplinary environment. The nonverbal implications of their behavior suggest that Chaplains should hurry up and pray and then get out of the way because pastoral care brings nothing to the interdisciplinary assembly of significance. The inference is that a man or woman of faith must tread very lightly and speak very sparsely and sparingly.

There are some members of the interdisciplinary hospital community who are men/women of faith and also display a healthy respect for the claims of hope and substance of faith. They represent a minority. On the other hand, many members of the interdisciplinary team are arrogant, irreverent, callous, ignorant, and disrespectful of things pertaining to the claims of hope and the substance of faith. They acknowledge and have respect for what is scientifically provable and/or empirically verifiable in tests, examinations, and in historic patient records. If Chaplains are not careful as men and women of faith, they could find ourselves abandoning the worth of the claims of hope and the word of faith and bowing down at the altar of the scientific technology of medical diagnosis and the speculation of prognosis in an attempt to ward off the seemingly



prejudicial backlash of the irreverent and unbelieving members of the interdisciplinary hospital community, whether real or imagined.

As men and/or women of faith, who are also members of the interdisciplinary hospital community, Chaplains do not encourage patients to participate in irresponsible behavior (i.e., being disobedient and/or being uncooperative). Nevertheless, if a responsible patient who is informed of, and understands, the implications of the scientific medical evidence presented and the possible natural consequences of noncompliance, and it is his/her idea to stay the course against treatment and walk according to the claims of hope and the word of faith, the Chaplain, as a man of faith, must respect the right of the patient to do as his/her faith demands. Likewise, in good conscience, the Chaplain can support the patient's decision to do so, according to the claims of hope and the word of faith.

### **Chaplain Is Spared from Spinal Cord Injury Trauma to Serve Paraplegics and Quadriplegics**

As stated before, the author's unique approach to ministering to the Spinal Cord Injury population, of this hospital and the utilization of his theological perspective of Pastoral Care is qualified by a near-death experience that the author had during his years as an undergraduate college student at Morris Brown College in Atlanta Georgia. The author experienced a very terrible automobile accident while driving his father's white, four-door, 1960 Pontiac Catalina. The car was completely demolished, when the author crashed into a giant oak tree. The car was so badly damaged, that his father and friends would never let him see the wreckage, they just told him about it. The police officer attending to the scene of the accident said: "I know that the driver of this car is dead

because no one could have survived this crash and live.” A friend told the officer that the author was alive. The police officer said: “if he did he survive, he will be crippled for life.” The author is pleased to be able to report to you that he not only survived that serious accident by the grace of God, but he prevails to this day, to the glory of God, in spite of his historic worldly lifestyle and his litany of selfish personal choices.

When the author reflects upon his present place in the body of Christ, he must witness to the validity of the amazing grace of God. Forgiveness and repentance is alive and well within the body of Jesus Christ and Father God is still in the business of reconciling and recycling the lives of the legitimate descendants of the fallen estate of Adam. The Lord saved him when he was a church attendee/choir member, born in a parsonage and raised in the assembly of believers, but not a serious Christian. It was a time in his life when he was consumed with carnal pleasures, educational pursuits, and other personal agendas while fulfilling the selfish and lustful desires of his youth. Furthermore, the author did not have a cognitive theological perspective that was operative in his life or influenced the decisions that he made about the present or the future. Since the author does not believe in “luck,” he must conclude that he survived the seductions of his youth and the error of his ways by the intervening hand of Father God, His divine protection, and His active cords of mercy that drew the author towards Him. The Father reconciled the author into a righteous relationship with Him in the body of His first and only begotten Son, instructed his heart and mind, and secured his destined place in the ministry of the gospel of the Lord Jesus Christ. (See John 6:44-45.) Therefore, instead of being ministered to as a possible paraplegic or quadriplegic with a significant degree neurological impairment, the author has been spared the agony, trials, and suffering of that crippling experience of physical, mental and spiritual anguish. On the contrary, the author

is blessed to minister to the population of the Spinal Cord Injury population at this hospital as an intentional caregiver and a willful participant in the body of Christ. But for the grace of God, the author would be a paraplegic or quadriplegic patient. There is no sense of personal perfection registered in his mind or in his heart. The author is a sinner, saved by grace, but a sinner, nonetheless.

In this non-church/hospital setting, the author does not approach any patient as an overt evangelist, even when he feels the urge to do so. He knows that he is in a multi-ethnic, multi-cultural, poly-religious, pluralistic environment. The author intentionally “slows his roll” and seeks to engage each person in less-threatening, light-hearted, mildly intrusive dialogue. The author presents himself as an open, friendly person, willing to speak an encouraging or complimentary word to any patient, to lend a helping hand where he can, to offer himself as fellow human being on the journey of life, as a fellow disabled veteran of the USAF, and as representative of the Pastoral Care department of this hospital. If asked, the author will share his Christian identity as a son of Father God in Christ Jesus and his empowerment in the Holy Spirit. It is his acquired status and capability as a redeemed and empowered son of the economy of Heaven that allows him to be relevant, empathetic, sympathetic, instructive, teachable, productive, and even comfortable, in this pluralistic atmosphere and in the dynamic process of the delivery of effective ministry. Otherwise, the author practices the intent and context of his Judeo-Christian confession and witness in non-specific, non-verbal ways, without overt conversational references to his personal theological perspectives and/or positions. (See 1 Peter 3:1-5.)

## **BIBLICAL FOUNDATION IN SUPPORT OF A MINISTRY OF PASTORAL CARE**

Ephesians 6:10-18 (KJV) says the following.

(10) Finally, my brethren, be strong in the Lord, and in the power of his might. (11) Put on the whole armor of God that ye may be able to stand against the wiles of the devil. (12) For we wrestle not against flesh and blood, but against principalities, against powers, against the rulers of the darkness of this world, against spiritual wickedness in high places. (13) Wherefore take unto you the whole armor of God that ye may be able to withstand in the evil day, and having done all, to stand. (14) Stand therefore, having your loins girt about with truth, and having on the breastplate of righteousness; (15) And your feet shod with the preparation of the gospel of peace; (16) Above all, taking the shield of faith, wherewith ye shall be able to quench all the fiery darts of the wicked. (17) And take the helmet of salvation, and the sword of the Spirit, which is the word of God: (18) Praying always with all prayer and supplication in the Spirit, and watching thereunto with all perseverance and supplication for all saints.

A Biblical Foundation in support of a ministry of Pastoral Care must be established upon the premise that all of us as the descendants of Adam in the Earth live in the midst of a violent, multi-level, spiritual, mental and physical war-zone. The conflicts and troubles of this world, the miseries, agonies and sufferings of this life, and/or the plagues of sickness and diseases of this existence, prey upon the mind, body and spirit, of both the traumatized and untraumatized among us without respect of persons. It is tantamount to each of us being at war, whether we are unsaved or saved.

The unsaved can appeal to the historic and contemporary remedies and solutions offered by psychological and sociological scientific research, philosophical postulations and speculations, and personal, historic experiences about how to navigate through this life.

For the saved, there is the added comfort and assurance of Jesus Christ, the Great Shepherd, communion within the Church, the assistance of the Holy Spirit, the protection of the holy angels, the veracity of the word of God, and the effectual prayer of the righteous saints of God. In that salvific context, the most appropriate scriptural foundation for such a premise of comfort and assurance is Ephesians 6:10-18 and James 5:13-16.

In Ephesians 6:10-18 (KJV), the Apostle Paul suggests that each soldier in the army of the Lord must be properly attired in the spiritual combat gear that he calls, “the whole armor of God.” Furthermore, the Apostle suggests that we might want to presume that the battles for our souls only occur on a physical and mental level, when in fact we are wrestling against third party spiritual beings called principalities, powers, rulers of the darkness, against spiritual wickedness in high places. Since this is the case, we need to be able to do spiritual warfare in heavenly places while wearing “the whole armor of God.” And even as we are encouraged to acknowledge the role that each aspect of the whole armor of God plays in the defense of our souls, in verse 18 the Apostle admonishes us by saying: “Praying always with all prayer, in the spirit, and watching there unto, with all perseverance and supplication, for all saints.” In other words, the most perennial element of our spiritual warfare is the power of prayer.

James 5:13-16 (KJV) says the following:

(13) Is any among you afflicted? Let him pray. Is any merry? Let him sing psalms. (14) Is any sick among you? Let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord: (15) And the prayer of faith shall save the sick, and the Lord shall raise him up; and if he have committed sins, they shall be forgiven him. (16) Confess your faults one to another, and pray one for another, that ye may be healed. The effectual fervent prayer of a righteous man avails much.

The Chaplain is a member of the interdisciplinary team within the hospital environment. The one thing that the Chaplain can bring to bear upon the problems of the spinal cord injury patient and upon his/her desire to augment his/her physical, mental and/or spiritual condition for the better is the power of prayer. Without equivocation, prayer is an intentional act of subservience and worship towards the Sovereign God, Supreme Being and/or a higher power. In verses 13 and 14, the Apostle James asks a series of questions of both listeners and readers that require a response, along with receiving an anointing with oil, from the elders of the Church. Notice that it is not the oil that heals the sick. Verse 15 that the prayer of faith shall save the sick, and then the Lord, not the oil, shall raise the sick. In verse 16, the Apostle James comforts and encourages us further by saying: “the effectual prayer of a righteous man avails much” for each person who prays to our Sovereign Father God, in the name of Jesus.

In every instance, a hierarchical relationship is erected between the person making the prayerful petition on the Earth and our Sovereign Father God, the Supreme Being who receives and/or answers prayer, in the Heavens.

Hebrews 11:6 (KJV) says:

(6) But without faith it is impossible to please him: for he that comes to God must believe that he is, and that he is a Rewarder of them that diligently seek him.

The Literal Translation Word Sequence (LTWS) rendering of Hebrews 11:6, is a bit more precise in context. It says:

Apart from faith, we have no power to please. For he who comes towards God, must believe that He exists, and He becomes a Rewarder, in the ones diligently seeking Him out.

Consequently, prayer is not only about getting an answer to a request or supplication. Ultimately, the worship of a prayer is about “accessing and possessing the

power to please God.” Then the worship of prayer is about willfully approaching God, diligently seeking Him out, and thereby pleasing God. Those who please God are the ones He rewards according to the counsel of His own will.

The author’s personal methodology for obtaining optimum results from medical, sociological and psychological models of healing and wholeness is for each Spinal Cord Injury patient to fully cooperate with treatment plans and discharge plans, along with goals and objectives adopted by the Interdisciplinary Team. Responsible patients act and/or react in answerable ways. In some instances however, the patient is encouraged to participate in the creation and development of treatment plans in an attempt to get the patient to adopt the plan as his own and/or to buy into its implementation. The Chaplain never encourages patients to rebel against treatment plans and/or discharge plans or to disobey the Doctor’s orders and the directions of the nursing staff. Yet, we do acknowledge that it is a decision that the patient has the right to make for himself. Nevertheless, the Chaplain knows that occasionally there comes a time in the treatment process when alternative modalities of healing must be given serious consideration. The modality that we are suggesting can be enacted without insurrection or rebellion on the part of patients within the Spinal Cord Injury population. Therefore, the Biblical basis or support for the author’s personal methodology of affect/results is a prayerful one. It is founded upon and/or grounded in the author’s concept of the proactive spirituality of the Holy Bible for those who conform to the mandates of its intent and context, for curative considerations.

The author’s concept of spirituality is not secular, psychosocial scientific, philosophical, sectarian or ecumenical in its motivation. The basis for his personal context of spirituality is expressed in the intent and content of the collection of the Judeo-Christian

Scriptures and his fixed, ordered, hierarchal relationship with the Triad of members within the estate of the Godhead: (1) The Sovereign Father God, (2) His first and only Begotten Son God, Jesus Christ, and (3) God the Holy Spirit. When a patient within the Spinal Cord Injury population invites the Three Members of the Godhead into his/her pursuit of healing and wholeness, he/she augments the existing treatment plan and discharge plan without resorting to rebellion and disobedience.

This is the author's Biblical Foundation for Pastoral Care, and also his personal methodology, for confronting the healing and wholeness issues of patients in the Spinal Cord Injury population, so that they can be in position for them to possibly experience miraculous interventions by the Godhead, through faith.

In The Living Bible Paraphrased (TLB), Hebrews 11:1 says the following: "Faith is the confident assurance that something we want is going to happen."

In the New International Version of the Bible (NIV), Hebrews 11:1 says the following: "Faith is being sure of what we hope for and certain of what we do not see."

In other words, traumatized patients in the Spinal Cord Injury population must engage in a faith/hope exercise of prayer and will in accordance with the word and will of God in order to be in position to obtain "the substance of things hoped for" and/or "the acquisition of the evidence of things not seen." This is the methodology of the Spirit of God that is necessary when "other" tactics towards healing and wholeness are unprofitable and/or unproductive if you have time to wait that long. The practice of medicine is important for the physical health and well-being of the Spinal Cord Injury patients when you have time on your side. The complementary art of nursing is necessary to foster a caring atmosphere of recovery and convalescence. The resuscitation and rehabilitation remedies of the physical and psychological aspects of the Spinal Cord Injury population



are appropriate endeavors for sociological and psychological scientists. However, there are goals that this patient population must confront, and objectives that the aforementioned disciplines cannot address because these goals and objectives are of a spiritual nature.

The author hastens to say that the capacity to have faith and the ability to believe can address the needs, goals and objectives of the Spinal Cord Injury unit population, which have escaped them through the employ of the theories and practices of the aforementioned scientific approaches to healing and wholeness. After a patient has tried all of the aforementioned approaches to healing and wholeness, it is never too late to begin to believe that his/her faith in the spiritual, supernatural processes of God can make a difference for him/her. Likewise, the believing patient needs to know that none of his/her efforts to believe towards Father God for the impossible and/or the improbable go unnoticed by Him. In His sovereignty, God can suspend the rules and constraints of science, erase the seeming advantage of sickness and disease, cancel the chemical power and bondage of drugs, decide to be proactive towards believers, and reward those who please him and diligently seek His face. No effort of faith towards our Father is too small or irrelevant before His Face. Comparatively speaking, hopelessness is worse than helplessness when you are in a life-and-death situation. For if a patient is truly hopeless, he/she is eternally helpless from a spiritual point of view.

Finally, to believe that our personal efforts of prayer can make things happen all by itself is an inverted misnomer. To be sure, it can be very frustrating and misleading for the neophyte Christian, the novice believer, and/or the prospective convert, because answers to prayer do not always manifest themselves immediately. Literally speaking, it is often stated by some that "prayer changes things." In and of itself, prayer does not change

things. For if this “upside down” concept of prayer were true, it would represent an infringement upon the sovereignty of the will of God. That concept or understanding of prayer is very different from believing that our Sovereign Father God is able to respond to and/or answer our prayers when we petition Him in the name of His Son, Jesus Christ. This is very different from espousing the erroneous principles of mind over matter, positive thinking and positive affirmations uttered by a man/woman, saved or unsaved. If that was the case, patients in the Spinal Cord Injury population could be healed and/or made whole through the simple initiation of certain kinds of wholesome processes of their minds in conjunction with the utterance certain binding incantations.

Prayer is a worshipful, universal proposal, requesting Father God to move in and/or act upon or even against our infirmities and/or diseases of mind, body and/or spirit, to heal us and/or to make us whole in the name of the Lord Jesus Christ.

### **Historical Foundation And Philosophy Of Pastoral Care**

A history and philosophy of Pastoral Care involves the inclusion of the focus of the theological and biblical foundations of this model of ministry. It is an overview and modus operandi of their hierarchical order and interrelationship to one another in the delivery and/or realization of every ministry moment(s).

The Chaplain must know who he is ministering to as patients from a historical and philosophical perspective, informed by research data and literature from existing projects and models of ministry. The Chaplain must be well acquainted with his biblical foundation and theological perspective of Pastoral Care in order to synthesize them with his historical and philosophical perspectives and be able to utilize the resulting configuration to minister to the traumatized Spinal Cord Injury patient population. Therefore, in blending his

understanding and utility of theological, biblical, historical and philosophical perspectives, the author is determined to be able to encourage the pursuit of healing and wholeness by SCI patients within the traumatized target population. The author is well aware of the fact that every traumatized SCI patient may not experience a complete recovery from a medical scientific point of view. However, a level of healing and wholeness of the mind, heart and spirit are possible without a return to normal, autonomic, central and peripheral nervous system functions. It would be like a prisoner serving a life in prison without the possibility of parole. Yet, within his/her own mind, heart and spirit, he/she would be at peace with God, with others, with the world, and with their unique circumstance of spinal cord injury trauma.

In other words, the Chaplain must be able to identify the target population, historically and philosophically, and to acknowledge the function of his theological perspective and biblical foundation within this synthesis in his personal strategy of caregiving in order to interface effectively with patients in the target population. The objective for accessing the lessons and strategies of history and blending them with theological and biblical perspectives is to be able to deploy a plan of action that will move patients toward the willful consideration and acceptance of an approach to healing and/or the restoration of the desire to move towards wholeness, within patients in the target population.

For the most part, the author's historical and philosophical view of Pastoral Care envisions the Chaplain in the role of a Coach in relation to a patient(s) within the Spinal Cord Injury population. The author was watching a program on the Golf channel called "Golf Talk Live." The guests on the program were Mr. Tiger Woods and his Swing Coach, Mr. Butch Harmon. After his historic victory at the Master Golf Tournament in August Georgia 1998, Mr. Tiger Woods stated that in order for him to become a

consistent winner on the PGA Tour, he needed to be able to execute an exact replica of his best swing for the relevant conditions in every kind of situation on a regular basis. Though he was a professional golfer at the very top of his game, he concluded that he needed the assistance of a teaching professional that he respected and trusted to help him completely reconstruct his golf swing, from top to bottom. This was not a widespread practice at that time among players in the professional ranks. Therefore, the stated objective for establishing this teacher/student relationship was to develop a cognitive golf swing pattern, which Mr. Woods could reproduce over and over again especially in stressful conditions and under extreme circumstances. Mr. Woods stated that, as a golfer, he had to stop being who he was historically, which meant that he had to stop doing what he did instinctively, unconsciously, and/or automatically. Every aspect of the mechanics of his golf swing had to be studied, analyzed and evaluated to determine whether it was a benevolent or malevolent part of the process. At times, it appeared that Tiger Woods had made a mistake in trying to obtain his stated objective(s). Subsequently, he did not win as many golf tournaments as before in dramatic fashion. Many “result oriented” golf analysts and color commentators were quick to judge Tiger Woods harshly, saying that his meteoric rise to golfing prominence was a fluke or a stroke of luck. On many occasions, he appeared to be indecisive, baffled, and otherwise frustrated on the golf course in situations where he previously excelled to the delight of gallery and to the amazement of his peer professionals. In the interviews that followed, Tiger never spoke of the specifics of his undertaking with his Coach except to say that he had to unlearn some of his old, ingrained habits and become entrenched in new habits that moved him toward his established objectives. During these difficult and disappointing times, Tiger would come close to victory on several occasions, but a seeming miscue here and there and the

reconstructive instability associated with a golf swing in progress caused him to fall short of the winner's circle on several occasions.

No doubt, the Coach wanted to do more to ensure that his student would realize his objectives, but as a Coach, he must remain on the sidelines during stroke play and/or match play, observe the mechanics and demeanor of his student, and then convey to him what he detected as the event progressed towards a conclusion. Some of the commentators and/or news reporters would say that Tiger Woods is in a terrible slump.

However, the author noticed that in some of the interviews that followed, Tiger would always find something complimentary to say about the way he played; things like: "I struck the ball well today," or "I rolled the ball well on the putting surface today," or "my mechanics were sound today," or "we're almost there in relation to our objectives. With a little luck, a ball landing a couple of inches to the left or right could have made a big difference in the outcome of this tournament," or something of that nature.

Apparently, Tiger and Butch had some secondary objectives that were to be addressed and/or accomplished during each round of golf. Of course, the primary of objective of entering into every tournament to win the prize was always at the top of their list. However, if that did not occur, Tiger seemed to obtain a degree of satisfaction from having realized some of his complementary objectives and to learn more about the new adjustments he was making as he progressed in execution and proficiency in pursuit of reconstructing his golf swing and in the re-packaging of himself.

As a Chaplain, the author learned several things from "the student/Coach relationship" (i.e., primary part/counterpart between Mr. Butch Harmon and Mr. Tiger Woods.) First and foremost, the student must trust and/or have faith in the voice of his Coach as his instructor above all other voices and that the "composite entity one type

relationship” (i.e., the student/Tiger Woods and Coach/Butch Harmon) will be beneficial for him. Secondly, the student must have confidence in quality of the instructions he is receiving and in the integrity of his Coach, who offers guidance and shares relevant information, as a channel of tutorial feedback and/or inspirational reflective conversation. Thirdly, if the student does not know who he is in the reconstructive process and if the student is unclear about the nature of the path towards his primary and secondary objectives, unrelenting critics can cause the student to lose his focus and/or cause him to become angry and frustrated with the reconstructive, repackaging process.

Butch Harmon stated that Tiger Woods is a Coach’s dream as a student because he has skills to start with. He listens attentively and intelligently. He is a superbly conditioned athlete and he does what is asked of him, even if he can’t visualize its benefit to the reconstructive process at the time. Mr. Woods stated that Mr. Harmon is a friend and Coach, that he admires, respects, and trusts to help him perfect the optimum golf swing. Mr. Tiger Woods continued to practice his golf swing under the watchful eye of his Coach, Mr. Butch Harmon.

The Coach cannot swing the clubs for his student, but he can instruct, instill and inspire his student to reach deeper depths, and higher heights of perfectly controlled execution. Shortly thereafter, Tiger began to show evidence of their *combined commitment* to the realization of the stated objectives. Subsequently, they celebrated the fruits of their labors together when Mr. Tiger Woods became the first golfer in the modern era to hold all of the prestigious major golf tournament titles as a champion at the same time: (1) The United State Open Championship, (2) The British Open Championship, (3) The Augusta Georgia Masters Championship, (4) The Canadian Open Championship, and (5) The Professional Golfers Association Championship. Particularly, the news media

dubbed it “the Tiger Slam” because his possession of the championship sequence of golf tournaments did not all occur within the same calendar year.

As a Coach of patient(s) within the Spinal Cord Injury population, the Chaplain/author’s participation is limited to exciting, encouraging, cajoling and coaxing patient(s), in the pursuit of his/her healing and wholeness of objectives. As a Coach/Chaplain, the author attempts to assist in the education and edification of the mind, the inspiration and support of the heart, and the encouraging and bolstering of the spirit, of the patients within the Spinal Cord Injury population. By the grace of God, the Chaplain/author is not a Spinal Cord Injury patient. Nevertheless, what he does as a Coach/Chaplain in the role of a counterpart is important to the realization of the wholeness/healing objectives of the patient(s). The patient must willfully occupy the exalted position and role of the primary part in this fixed ordered, hierarchical relationship. The Chaplain cannot perform miracles in and of himself, but he can prayerfully and sincerely pursue them and earnestly believe that they are possible and attainable when “they (i.e., patient/Chaplain)” involve themselves with the Triad members of the Godhead and invite “the Three of Them” into their prayerful procurement process in the name of Jesus Christ. As a possible member of “a composite one type union” (i.e., patient/Coach relationship) within a fixed ordered interrelationship, both the patient and the Chaplain must remain in relentlessly pursuit of the objective(s) of “the primary part” (i.e., the patient), the realization of healing and/or wholeness. After all, when they cut to the chase, they must acknowledge the truth of the following observation. In the final analysis, it is a spiritual pursuit. The optimum expression of mature spirituality is the worshipful endeavor of praying toward our Sovereign Father God in accordance with the intent and context of the word, will, and ways of God in the name of Jesus Christ by the help of the Holy Spirit.

When it comes to the question of interacting with patients on the Spinal Cord Injury unit, the author approaches it as “a private place in real time” where mutual respect and the unqualified acknowledgment of personhood generates authentic intimate encounters with fellow human beings. For the Spinal Cord Injury patient, interaction with others is not a priority and never will be. Likewise, dealing with the Chaplain is not a priority within the mind of the average Spinal Cord Injury patient. The Spinal Cord Injury patient is preoccupied with himself/herself and personal issues of relief from pain, discomfort and/or drug abuse issues. Consequently, when it comes to the experience of interacting with patients on the Spinal Cord Injury unit, the Chaplain does not enter into conversation with them with a predisposition towards arbitrary self-disclosure. The Chaplain must understand that self-interest assumes the position of top priority with patients in the Spinal Cord Injury population. Every encounter that the author has with a Spinal Cord Injury patient as a Chaplain does not require that he practice indiscriminate self-disclosure. As often as possible, the author tries to respect the patient’s right to privacy, acknowledge his/her need for personal space, and his/her never-ending quest for freedom from chronic pain and physical discomfort. The author is not always challenged to share his private life and personal history with the patients on the Spinal Cord Injury Unit. In most instances, they don’t ask those kinds of probing personal questions. Occasionally, someone will ask the Chaplain about his personal and private life, but it is not something that he is faced with on a daily basis. From the author’s perspective, each experience that could involve some form of self-disclosure is evaluated as an individual incident in and of itself.

The average age of a majority of the Spinal Cord Injury patients is approximately fifty-five years old. They are predominately white male patients, World War II, Korean



Conflict, and Viet Nam Era veterans. A majority of the Spinal Cord Injury veterans come to this hospital because they are dealing with serious health issues and/or coping with varying levels of chronic pain, physical discomfort, and/or drug abuse. In most instances, they ask very few questions about others because it is self-interest that consumes them. The author's conversations with Spinal Cord Injury patients start out rather casual and then gradually become more involved and more pointed as the relationship develops and/or intensifies.

Given the fact that the author is a disabled veteran historically, he has something in common with Spinal Cord Injury patients. During the first half of his residency as a Chaplain at the Louis Stokes VAMC, Cleveland OH, the author experienced a recurring and agonizing bout with the gnawing and excruciating pain of the sciatica nerve in his right leg that lasted for about three months. No matter what he did in terms of treatments, therapies and/or prescribed medications, the chronic pain and physical discomfort just would not relent or go away. By way of reflection, the author remembers that he was predisposed to dealing with the level and/or intensity of his own pain as a high priority. During that period of time, the author was not given to engaging in unnecessary conversation about the private and personal life of others. He was consumed with self-interest issues in one way or another. He just wanted relief from chronic pain, physical discomfort, and space to be preoccupied with himself and his concerns.

## **CHAPTER FOUR**

### **METHODOLOGY**

The Methodology utilized to facilitate this process will be the Case Study. The *Case Study* is an organized, systematic method of studying and reporting various aspects of a person, family, group or situation using a prearranged outline of questions or subjects. Within a clinically supervised environment or classroom setting, the case study is often utilized as a means of reporting, analyzing and evaluating a pastoral encounter and/or counseling session. That environment is the whole Veterans Affairs Medical Center. A series of verbatim(s) will be written in an attempt to present to the reader an accurate and clear recreation of the dialogue and interchange personalities that transpired within each encounter(s). In this instance the author will focus on one person, at a time.

### **Hypothesis**

The hypothesis of the Ministry practice says the following: Six weeks of Pastoral Care will enable each spinal cord injury patient to improve his/her quality of life by reducing the level of anger and the intensity of pain that could lead to illegal drug usage. Six weeks of Pastoral Care Ministry practice will include: (I) reflective dialogue; (a) Biblical interpretations and meditations (b) prayer and (c) memorization of Bible verses; (II) hospital visitation; and (III) artistic therapy and counseling for each patient.

### **Intervention**

During the six week period, the Chaplain determines to be involved with the patient during hospital visitation(s) in whatever area of the medical facility the Chaplain, finds the patient. The Chaplain will endeavor to be alert and attentive in an attempt to utilize the communicative elements of the hypothesis that will yield the most beneficial results for the needs and concerns of the patient. As a “counter conversationalist,” the Chaplain/Coach will offer constructive assistance to the patient without becoming unnecessarily judgmental and/or a full-blown advocate. As often as possible, the Chaplain/Coach will try to encourage the patient to take the leading role in these conversations.

### **Research and Design Case Study**

In the research and design of each case study, the author will review the “definition of terms section” enumerated in the hypothesis prior to engaging the patient in reflective dialogue and a counseling session. The Case Study is an organized, systematic method of studying and reporting various aspects of a person, family, group or situation using a prearranged outline of questions or subjects. Within a clinically supervised environment or classroom setting, the case study is often utilized as a means of reporting, analyzing and evaluating a pastoral encounter and/or counseling session.

### **Measurement Instrumentation**

The measurement of each case study will be accomplished through each file being read and reviewed by: the Chaplain, a Social Worker, Psychologist, Medical Doctor, Registered Nurse, and/or each SCI patient. Each evaluator will respond in writing.

### **Data Collection**

Data Collection will be accomplished when any three or more of the following professionals—the Chaplain, Social Worker, Psychologist, Medical, and/or Registered Nurse—prepare a *Written Case Evaluation Form* and respond to the following series of questions in the Case Study Evaluation Form.

### **Case Study Evaluation Form**

- I. Give me feedback about the effectiveness of my variables of pastoral care ministry:
  - (1) Reflective Dialogue:
  - (2) Biblical Interpretation and Meditations:
  - (3) Prayer:
  - (4) Memorization of Bible Verses:
  - (5) Hospital Visitations:
  - (6) Artistic Therapy and Counseling:
- II. Tell me how my presence as a Chaplain benefited the patient.
- III. Tell me if and how my role as a Chaplain has affected the patient's issues of:
  - (a) Anger:

(b) Pain:

Pastoral Care Observation:

Psychological Observation:

Sociological Observation:

Spiritual Observation:

Summary:

### **Analysis of Data**

In the Analysis of Data, the author will read and review all of the Written Case Evaluation Forms. Then, he will draw conclusions about their intent and context in regard to the stated hypothesis of this document. Triangulation will be accomplished when the data of at least two of the aforementioned professionals, along with the data of the Chaplain, are utilized to document the items listed on the *Case Study Evaluation Form*.

### **Description of the Spinal Cord Injury Patient Population**

The field experience takes place on the Spinal Cord Injury Unit in the Louis Stokes Veteran Affairs Medical Center of Cleveland Ohio. Primarily, there are two kinds of patients on the Spinal Cord Injury population: (1) the traumatized victims of Spinal Cord Injury incidents and/or accidents, and (2) the non-traumatized victims of autoimmune system diseases and/or degeneration such as Multiple Sclerosis, Fibromyalgia, etc. The common denominator possessed by both traumatized and non-traumatized patients is that both conditions involve the action and/or reaction of the motor and sensory nerves to impulses sent from the brain within the autonomic nervous system.

For example, in Spinal Cord Injury patients, the impulses are sent from the brain of the traumatized person, but the messages never reach or register in the motor or sensory nerves as an expected act, or predictable action.

In Multiple Sclerosis and Fibromyalgia patients, the impulses that are sent from the brain of the untraumatized person are received and registered in the motor and sensory nerves. However, the distorted messages received by deteriorating ligaments, weakened tendons, and/or debilitated muscles are nothing more than spasms, shudders, tremors, and discontinuous contractions.

In order to describe the wide spectrum of patients in the Spinal Cord Injury population of this hospital, we must understand the relationship between the components of the autonomic nervous system, the spinal column, and the way that each patient experiences dysfunction either as a loss of motor nerve and/or sensory nerve function or as the result of the receipt of distorted messages in the extremities of the peripheral nervous system. At some level, the autonomic nervous system stimulates the muscular system because muscles operate with and/or respond to some form of micro-electrical energy.

The spinal cord is the major assembly of nerves which take/transmit to and from the brain to the remainder body. The brain and spinal cord comprises *the central nervous system* (CNS), whereas motor and sensory nerves outside the CNS make up *the peripheral nervous system* (PNS). Collectively, the central and peripheral systems are called *the autonomic nervous system*. The ring of bones surrounding the spinal cord is called the vertebra/backbones. The spinal canal is formed by the assembly and juxtaposition of vertebra made up of four groups of vertebrae: a) Cervical, b) Thoracic, c) Lumbar and d) Sacral. The spinal cord rests inside of the spinal canal formed by the adjacent contiguity of the vertebra of the spinal column (a.k.a., the backbones). Thirty

(30) pairs of sensory nerves and motor nerves originate within the spinal cord: (1) eight (8) cervical [i.e., *the neck*], (2) twelve (12) thoracic [i.e., *the chest*], (3) five (5) lumbar [i.e., *the lower back*] and five (5) sacral [i.e., *the tailbone*). Each nerve exits between adjacent openings in the complementary vertebrae. The number of each spinal cord nerve corresponds to the number of the associated vertebrae where it exits from the spinal column with the exception of the cervical or neck vertebrae where there are eight nerves and seven vertebrae.

When the spinal cord is traumatized and/or injured, it can cause a loss of functionality, such as mobility and/or sensation detection. Frequently, trauma of the spinal cord comes from automobile accidents, falls, acts of violence, work-related activities, sports activities, etc. Additionally, there are non-traumatic causes of spinal injuries, such as cancer, Multiple Sclerosis, Fibromyalgia, spinal cord vascular disease, etc. Furthermore, the spinal cord does not have to be severed for a loss of sensation or motor function to occur. Interestingly enough, the spinal cord is intact in many traumatized patients with spinal cord injuries. And yet, a small bruise to the spinal cord that has healed can cause a discontinuance of the transmission and/or receipt of motor messages and sensory sensation to the extremities of the peripheral nervous system.

All motor nerve impulses and sensory nerve stimuli originate with and/or respond to directives from the brain, both voluntary and involuntary. Spinal cord injuries can manifest in varying degrees of neurological impairment, which is motor and/or sensory loss of impulses and stimuli from the brain. It depends upon where and to what extent the spinal cord has been traumatized or injured. Usually, patients injured in the cervical segments of the spinal column experience the greater frequency and degree of dysfunction involving a loss of motor and sensation functions in the arms and legs. Trauma in the

thoracic segments usually manifests as a loss of motor and sensory functions in the chest and legs. Finally, trauma to the lower back and/or tailbone segments manifest as a loss of function, motor and sensation in hips and legs.

Many involuntary processes and functions in the traumatized and/or non-traumatized body can be either lost or seriously impaired. Patients being damaged in the cervical region can experience greater degrees of dysfunction, losing the capacity to breathe without the assistance of respiratory machinery, loss of bowel and bladder control, the inability to stabilize blood pressure, and control body temperature. Spinal cord injuries can often impair sexual functions and reduce fertility in traumatized and non-traumatized patients.

Some spinal cord injury patients will experience varying levels and/or intensities of chronic pain. Many patients report that medication does not remove the pain completely. Drugs simply reduce the intensity of painful episodes and/or make the gnawing aggravation less severe and more bearable. There are some Spinal Cord Injury patients who experiment with illegal drugs in a failed attempt to medicate themselves and thereby alleviate their chronic pain concerns. In some instances, self-medication practices using illegal drugs can complicate, undermine, and/or otherwise compromise the integrity, timetable, and/or objectives of a well-conceived treatment plan.

Multiple Sclerosis is a non-traumatic disease that falls under the heading of an autoimmune disease. In other words, the immune system of the body attacks healthy fatty tissue surrounding nerve fibers and treats it like a viral infection. It often begins with pains in the neck and shoulders and extends down into the back, even into the joints, ligaments, tendons and muscles. The fatigue associated with Multiple Sclerosis is an anxious, uncomfortable weariness related to a lack of sleep and a disruption of the energy



production mechanisms in the cells, either from a lack of oxygen or an increase in toxicity, infections or a malfunction of the mitochondria (i.e., an organelle, inside each cell of the body, which manufactures energy). Sleep Disturbance: About 80% of the patients wake up three to four times per night. In some cases, they don't wake up at all, but in the morning they still feel like a truck ran over them. The reason being that when you have Multiple Sclerosis, subliminal seizures kick you out of the stage 4 sleep state to the stage 1 sleep stage so you can't sleep deeply and aren't rested. Short Term Memory Loss: Because of a low thyroid secretion and heart complications typical of Multiple Sclerosis patients, there is a decrease in blood flow to the left lobe of the brain resulting in an oxygen deficiency in the brain that causes the memory loss and forgetfulness so common in Multiple Sclerosis patients. Some other symptoms of this autoimmune disease are: Emotional Liability, Depression (not clinical depression as with emotional symptoms), Low Thyroid Function, Gastro-intestinal Problems, Swollen Glands, Chemical Sensitivity, Headaches, Low Blood Sugar, Candida Yeast Infections, Tingling hands, Ringing Ears, Cold Feet, Cold Fingers, Metallic Taste in the Mouth, Fluttering Heart, Panic Attacks, Rapid Heartbeat, Mitral Valve Prolapse (a two-flap, forward valve in the pulmonary side of the heart).

If a patient has Multiple Sclerosis, it is not likely that he/she has all these symptoms. Because of the more specific attack on the nerves of the peripheral nervous system, Multiple Sclerosis will cause other much more debilitating symptoms which can result in death cause by the destruction of the myelin sheath (i.e., *insulation for nerves*). This is the primary rationale for housing Multiple Sclerosis patients on the same unit with Spinal Cord Injury patients.

As a malfunctioning immune system is a major problem in Multiple Sclerosis, the place to start understanding Multiple Sclerosis is in the immune system. Some researchers feel that autoimmune diseases (and Parkinson's) are caused by consumption of aspartame (present in diet drinks, Equal, Nutra-sweet) and/or MSG (mono-sodium-glysomete). If you drink diet sodas, or commonly consume either of those chemical excito-toxins, "stop." They may cause many of you to exhibit Multiple Sclerosis symptoms.

### **The Chaplain's Near-Death Experience Increased His Empathy and Sensitivity to the Needs of SCI Patients**

Once again, the author's view of ministry to the Spinal Cord Injury population of this hospital, and the utilization of his theoretical foundations of Pastoral Care is surely qualified by a near-death experience that the author had after his sophomore year as an undergraduate college student at Morris Brown College in Atlanta Georgia. The author shudders when he calls to mind the automobile accident and what could have happened to him, if not for God's grace and mercy. The car was completely demolished when the author crashed it into a large oak tree. The car was destroyed. The author was never permitted to see the wreckage. Friends and family told him about it. The attending police officer at the scene of the accident said: "I know that the driver of this car must be dead because no one could have survived this crash and live." A friend told the officer that the author was alive. Then police officer said: "if he did he survive, he will be crippled for life." The author is pleased to be able to report to you that he not only survived that serious accident by the grace of God, but he prevails to this day to the glory of God in spite of his historic worldly lifestyle and his litany of selfish personal choices.

When the author reflects upon his present place in the body of Christ, he must witness to the validity of the amazing grace of God. Forgiveness and repentance is alive and well within the body of Jesus Christ and Father God is still in the business of reconciling and recycling the lives of the legitimate descendants of the fallen estate of Adam. The Lord saved him when he was a church attendee/choir member, born in a parsonage and raised in the assembly of believers, but not a serious Christian. It was a time in his life when he was consumed with carnal pleasures, educational pursuits, and other personal agendas while fulfilling the selfish and lustful desires of his youth. Furthermore, the author did not have a cognitive theological perspective that was operative in his life or influenced the decisions that he made about the present or the future. Since the author does not believe in "luck," he must conclude that he survived the seductions of his youth and the error of his ways by the intervening hand of Father God, His divine protection, and His active cords of mercy that drew the author towards Him. The Father reconciled the author into a righteous relationship with Him in the body of His first and only begotten Son, instructed his heart and mind, and secured his destined place in the ministry of the gospel of the Lord Jesus Christ. (See John 6:44-45.) Therefore, instead of being ministered to as a possible paraplegic with a significant degree neurological impairment, the author has been spared the agony, trials, and suffering of that crippling experience of physical, mental and spiritual anguish. On the contrary, the author is blessed to minister to the population of the Spinal Cord Injury population at this hospital as an intentional caregiver and as a willful participant in the body of Christ. But for the grace of God, the author would be a paraplegia patient. There is no sense of personal perfection registered in his mind or in his heart. The author is a sinner, saved by grace, but a sinner, nonetheless.

In this non-church/hospital setting, the author does not approach any patient as an overt evangelist, even when he feels the urge to do so. He knows that he is in a multi-ethnic, multi-cultural, poly-religious, pluralistic environment. The author intentionally “slows his roll” and seeks to engage each person in less-threatening, light-hearted, mildly intrusive dialogue. The author presents himself as an open, friendly person willing to speak an encouraging or complimentary word towards any patient, to lend a helping hand where he can, and to offer himself as fellow human being on the journey of life as a fellow disabled veteran of the USAF, and as representative of the Pastoral Care department of this hospital. If asked, the author will share his Christian identity as a son of Father God in Christ Jesus and his empowerment in the Holy Spirit. It is his acquired status and capability as a redeemed and empowered son of the economy of Heaven that allows him to be relevant, empathetic, sympathetic, instructive, teachable, productive, and even comfortable in this pluralistic atmosphere, and in the dynamic process of the delivery of effective ministry. Otherwise, the author practices the intent and context of his Judeo-Christian confession and witness in non-specific, non-verbal ways, without overt conversational references to his personal theological perspectives and/or positions. (See 1 Peter 3:1-5.)

## **CHAPTER FIVE**

### **CASE STUDIES**

The Case Study is an organized, systematic method of studying and reporting various aspects of a person, family, group or situation, using a prearranged outline of questions or subjects. Within a clinically supervised environment or classroom setting, the case study is often utilized as a means of reporting, analyzing and evaluating a pastoral encounter and/or counseling session.

#### **Case Study Preface: Interview with Dr. Thego Primary Physician to SCI patients**

The author was a Chaplain Resident in the Clinical Pastoral Education Program at the Louis Stokes Veterans Administration Medical Center, at Cleveland Ohio. The Clinical Pastoral Education Supervisor was Dr. Cecelia Williams, D. Min.

The author is pleased to present an interview that he conducted with Dr. Thego, a very dynamic physician on the medical staff at the Louis Stokes Veterans Administration Medical Center, Cleveland Ohio. She is the primary physician of Da Drummer, subject of one of our case studies. The author believes that this interview will give the reader an opportunity to view the doctor/patient dynamics that occur on the spinal cord injury unit. Dr. Thego was born in Germany under a communist regime. She is the fourth of seven siblings. In a previous conversation, Dr. Thego said that the Germans have done a lot of wrong things in the world. She said that she is trying to do some things that are good. Dr.

Thego was educated in East Germany and attended four schools, one of which was a medical school. The author believes that she perceives being a doctor as doing a good thing in the world. She was graduated from the University of Muester, in Germany, in 1964. Dr. Thego came to Cleveland Ohio in 1977.

#### Verbatim conversation

TH = Doctor Thego; TA = The Author

TA1 = Dr. Thego, I am the author, a Chaplain Intern here at the Louis Stokes Cleveland Veterans Administration Medical Center. I want to thank you for allowing me the privilege of interviewing you today.

TH1 = You are welcome. This shouldn't take anymore than five or ten minutes, should it?

TA2 = Probably not. Where are you from?

TH2 = I am from Germany.

TA3 = Oh yeah. What part?

TH3 = East Germany. *(She looks at the author, as if he might ask something about the wall of separation in Germany. The author started to do so, but he changed his mind)*

TA4= Are you an only child, the youngest child, or the oldest child?

TH4 = I am the fourth child. *(She raises her hand slightly, speaks sternly and says)*. This cannot be a personal interview. We must focus on my work.

TA5 = That's fine with me. I was only inquiring for the purpose of trying to determine if there was some one in your family or a close friend, who may have experienced a spinal cord injury trauma. *(She appeared to be ready to shut down the author, so*

*the author started to scramble, using a kind of apologetic tone and gestures trying to save the interview)*

TA6 = Dr. Thego, what were the circumstances surrounding your decision to become involved with the spinal cord injury patients?

TH5 = When I first came to the Cleveland VA hospital in 1977, I was assigned to the Pulmonary Medicine Department and remained there until 1991. As I recall, they didn't want me there and I didn't want to be there. About that time, a doctor in the spinal cord unit was retiring and they needed a doctor to fill that position. I accepted that position then, and I am still in the spinal cord injury unit today.

TA7 = Dr. Thego, I know that, for the most part, medical doctors are trained to use a scientific, impersonal approach to the practice of medicine. Also, many of them are quite detached from their patients. Yet I notice that you seem to have a kind of a "touchy feely," personal way of addressing each patient and making eye contact with them, even the ones who have warning signs on their doors.

TH6 = Well, that may or may not be a good thing. I don't know. I was not aware that I was doing it to that extent. I guess that it is all a part of my personal philosophy of treating each patient in relation to his/her chart. You see, the chart is very important because it is a record of the scientific facts about the patient, his/her medical history, the test results, surgical procedures, etc. For me, the patient is separate from his/her chart and the patient is more important than the chart itself. Now, there are some doctors that make all of their decisions based upon the information in the chart and sometimes without ever seeing the patient. Every doctor develops his own philosophy of the practice of medicine. As I see it, the patient is in charge and the doctor is the servant. As I proceed, the patient

continues to be in charge and comes to the doctor for assistance. As the trust and respect factors grow, the patient puts the doctor back in charge of the proceedings.

TA8 = I must say, Dr. Thego, that yours is a very different approach among your contemporaries. Personally, I haven't seen many modern doctors use that approach to the practice of medicine. For me, that approach is a kind of throwback to the days when family doctors made house calls and developed personal relationships with their patients.

TH7 = Well, that's my way of doing it. Around 1989, I took four courses in "Bioethics" at Cleveland State University. Much of what I do as a physician was being advocated in those courses. For me, it was an endorsement of my method and personal philosophy of practicing medicine. To that end, I see myself as a kind of "patient advocate." The patient is in charge. What I do is provide several options for the patients, inform them of the effects and consequences of those options, so that they can make informed decisions. From the decisions dictated by the patients, treatment strategies and modalities are established.

TH8 = *(Dr. Thego began to laugh a little bit, in a very relaxed and comfortable manner, as if contemplating something at a distance, then she said)* Have you seen the Maytag appliances commercial?

TA9 = Yes! It's one of my favorite commercials.

TH9 = It's about appliances that are made by superior craftsmen. They are made so well that they never need to be repaired. *(She laughs heartily, but lightly and says)* That's my fantasy about the practice of medicine, patients that stay well and



healthy and never get sick or patients that we treat and they never have to visit a doctor again.

TA10 = I must say, that's quite an interesting fantasy. It parallels my own fantasy, that is, to rescue the perishing and the lost as I try to preach myself out of a job, Christians who hear a good sermon, and never have to hear it again. (*We both laugh for a minute and elaborate on our fantasies*)

TA11 = I've wanted to interview you for quite awhile now, because you are so very popular with your patients. Da Drumma is one of your patients. So many of your patients speak so highly of you and care so much for you. They say that they have established a rapport with you, that you know how to talk to them, that you listen to them and hear what they have to say. They say that they don't get to see you enough because you are busy serving your patient load. They say that the patient/doctor ratio has increased to the point that you don't get to visit them as frequently as they would like.

TH10 = True enough I am busy. But I also like to give the patients the impression that I am busy because I don't want them to be too dependent on seeing me whenever they decide that it's necessary. The truth of the matter is that sometimes the patients have legitimate issues and other times it's a control issue. Most of the problems on the spinal cord injury ward are control issues driven by anger and frustration. It comes down to the question of who is in charge on the ward.

TA12 = So, there is a point in the doctor/patient relationship where you take control and at that point you determine when you will be accessible and/or available to a patient(s).

TH11 = Yes. That is correct.

TA13 = Dr. Thego what percentage of the patients on the spinal cord injury ward are angry?

TH12 = I would say that about 95 to 98% of the patient population is either angry or very angry. Some of it is subtle and some of it is overt. Comparatively speaking, these angry patients are in a traumatized state and the staff members are in an untraumatized state. They are angry because they cannot care for themselves. Furthermore, they are angry because they have to depend on untraumatized people for assistance in almost everything. They look at the doctors, nurses, office workers, and other staff members as being in an untraumatized state. In other words, the doctors, nurses, office workers, and staff members are the enemy because they are reasonably healthy and have mobility.

TA14 = I presume that Chaplain Staff would also be included in untraumatized group called the enemy.

TH13 = That is correct. You see the most important communication that takes place in the traumatized group is among patients. Peer communication between traumatized patients is very beneficial because they are all looking to exercise control over the enemy and to determine the degree to which they will allow the healthy untraumatized adversaries to exercise control over their traumatized bodies. As I stated before, all problems on the ward are always control issues.

*(Then, Dr. Thego began to produce a sketch, one that would represent the interrelationship between the administration, doctors, nurses, staff members and patients.)*

TA15 = Dr. Thego, thank you so very much for allowing this opportunity. I have benefited greatly from it. Thanks for letting me view the practice of medicine from your perspective.

TH14 = You are welcome. (*We left the location of the interview and went to our separate work locations and assignments, on the SCI unit.*)

In reflecting on the interview, the author learned that, from Dr. Thego's point of view, nearly all of the SCI unit patients are struggling with anger issues. Even though there is a constant struggle transpiring between the staff and the patient population, the SCI patients must be very careful. They are not free to express their anger indiscriminately because, as traumatized victims of SCI, they are completely dependent on the medical staff and nursing staff, respectively. Because of their anger issues and their constant involvement with the levels and intensities of gnawing and debilitating pain issues, they are both consciously and unconsciously preoccupied with the chronic pain and repressed anger syndrome while they are in the hospital setting of the SCI ward.

### **Case Study of Da Drummer**

Resident Student: The Author

CPE Supervisor: Dr. Cecelia A. Williams

Date Case Study: 06/01/04 to 07/03/04

Date of Interviews: 07/15/04 & 07/18, 07/22/2004

Location of interviews/study: Wade Park SCI    Interviews/studies numbers: 1 to 5

Interview number: - 1, 2 & 3

Patient pseudonym: Da Drummer

Patient age/sex/race: 48/Male/AA

Patient disease: Quadriplegia from Gun Shot wound

Religion: BAPTIST

Length of Visit(s): From 15 to 30 minutes

## 1. Background Information

Da Drummer is a 48-year-old African American Male, Vietnam era veteran in-patient from the City of Cleveland, Cuyahoga County, and from the State of Ohio. He is of the Baptist denomination. He has never been married. His spinal cord injury is the result of a gunshot wound. The patient's disability is not service connected. He is a former local musician in the Greater Metropolitan Cleveland Ohio area, a drummer in several jazz ensembles.

The Author became involved in this case study by chance, resulting from taking several pairs of his boots to a shoe repair shop located in the Harvard/Lee Shopping Plaza. The proprietor of the shop took notice of the author's Louis Stokes VAMC identification badge and remembered meeting him in the hospital room of Da Drummer as the author was making his daily rounds. The proprietor was there to visit with his friend and to reminisce with an old friend and fellow musician. The author told him that he was a musician also from the Atlanta, Georgia and New York City areas. From there, they traded old jam session exploits and "night-club" war stories about musicians and their personal preferences and opinions about jazz music, the Motown Sound of Detroit, Stax Records Sound of Memphis, Booker T and the MGs, Parliament Funkadelic, Bootsy Collins from Cincinnati, Jimi Hendrix from Seattle, the Meters from New Orleans, Earth, Wind and Fire from Chicago and Los Angeles, and Jazz Fusion from all over this land.

Eventually, the shopkeeper shared with the author that the physical condition and questions about "the self-medicating habits" (i.e., illegal drug usage) of Da Drummer were not acquired while he was on active duty as a soldier. From what I can gather, the shopkeeper said that the quadriplegic condition of Da Drummer resulted from his involvement in a drug-related lifestyle or possibly the business end of a drug deal gone

bad. In the confusion swarming around this woeful encounter, Da Drummer was shot twice in the back. One of the bullets nicked his spine, somewhere between vertebrae “C-2 and C-5.” Immediately, he became ill and was hospitalized. The prognosis of the Doctor was that he will never walk again and will never play the drums again. Initially, he was angry with the man that shot him. Then, he was angry at the world and everybody in the world. Finally, he was angry with the VAMC staff about his quadriplegic condition. In the mean time, Da Drummer was in a constant state of denial, in that he never took any responsibility for what happened to him. Instead, he blamed everybody but himself for his condition. He speaks often of a full recovery and about getting up, walking again and playing the drums again. This was the author’s introduction to this case study.

#### 2a. Preliminary Observation - 07/15/2004

Upon entering his room on several occasions, the first thing the author noticed was the constant sound of music on his radio. The radio is located on the windowsill with the antenna extended for good reception. Most of the program format is instrumental music. There is an occasional greeting card and a few tidbits here and there, scattered about his room. Every now and then he received a visitor from the old neighborhood.

#### 2b. Verbatim Account // Conversation - 04/15/2003

TA = THE AUTHOR and = DA DRUMMER

TA1 = *(I knocked on the door, and entered in . . .)* Morning Da Drummer . . . Chaplain-

TA here!

DD1 = Yeah, Chaplain, what’s up! *(As he speaks in a low whispery voice, a slight smile is shone upon his face)*

TA2 = I'm all right today . . . Say man, I ran into someone the other day that knew you, back in the 'hood. He told me that you were, as a musician . . . In fact he said that you were a drummer . . . He said that you play the drums very, very well!

DD2 = Yeah! I've played in clubs and lounges all over Cleveland, yeah, all over this town.

TA3 = He said that you were smooth, cool, and funky with your feet. In fact, he said that you were so funky, that at intermissions, they would throw you down, take your shoes off your feet, and hang your shoes outside the door, so that the patrons could get some relief from the "funk."

DD3 = *(Da Drummer smiles freely and grins frequently as he seems to be reminiscing about jam sessions, club dates, jazzy chicks, and other musical scenes of days gone by)* Yeah! I was a member of the musician's union . . . I still am . . . and I have my cabaret card too.

TA4 = Really?

DD4 = Yeah man.

TA5 = The dude that told me about you is a musician also . . . I think that he's a guitar player . . . I think he said that he remembers playing with you on several occasions . . . I think I recall him visiting with you, in this very room several months ago. Do you know who he is? Can you remember his name? *(He seems to be trying to remember the musician's name)*. I met him in a shoe repair shop in the shopping at the intersection of Harvard and Lee. It's called Towne's Shoe Repair . . . I think that he is the proprietor . . . I had seen the sign on several previous occasions. I needed to have some of my boots capped and resoled and when I took my boots into that shop, I made your friend's acquaintance.

DD5 = How did my name come up?

TA6 = First of all, I was wearing Louis Stokes VAMC identification badge at the time.

Secondly, he recognized me as the Chaplain that he met in this room. Thirdly, I am a musician too, a Bass Player in fact. Eventually, our conversation got around to music, jazz and guitars, etc.

DD6 = (*Da Drummer kind of looks over at me and says*). So you're a Bass Player, Chap?

TA7 = Yeah, but I have not done much playing in the past 10 to 15 years. In fact, all of my guitars are still in southern Ohio, under the watchful eye of a very close friend of mine. He is also a guitar player.

DD7 = I knew it was something 'bout you, Chap. You're cool and smooth, we vibe together. You know what I mean?

TA8 = Yeah, man. I noticed that you always got your radio playing, and tuned to same kind of music all the time; it must be the station with the cool jazz format. (*Then I noticed that, for the first time, Da Drummer's radio was not on and I asked the question*) Hey Drummer, what's up with you, why is your radio off today?

DD8 = I'm real upset with these people 'round here, Chaplain . . . They talkin' 'bout putting me out the hospital, Chaplain . . . talkin' 'bout putting me in a nursing home . . . I ain't going to no nursin' home . . . I ain't going to no nursing . . . I ain't goin' to no nursin' home . . . (*He keeps on repeating this phrase as he keeps on*).

TA9 = Who said that you were gonna' be put out this hospital and for what reason?

DD9 = They been talking to my mother and done scared her to death . . . getting them to say that they can't take care of me . . . and that the best thing for me would be for her to sign the papers to put me in a nursin' home. They can't do this to me . . . I'm a veteran . . . they can't put me out on the street . . . I ain't gonna' take this

lying down . . . I got me a good lawyer . . . I've been puttin' it off . . . but I'm gonna' have to get serious now . . . 'cause they talkin' 'bout puttin' me out, Chap . . . They got my momma all upset and confused about what's gonna' happen to me . . . They can't put me out . . .

TA10 = You say that your momma and daddy are all upset and confused about what's goin' on?

DD10 = Yeah! You see, Chap, they done tricked her into signing some papers that will authorize them to send me to a nursing home. They should not have done that.

TA11 = You say that your mother didn't know what she was doing and that she was frightened into making the nursing home request 'cause she is unable to take good care of you?

DD11 = Yeah Chaplain, they scared them, especially my mother (is scared) . . . *(The more we talked about it, the angrier Da Drummer got, his facial expressions and the movement of his head and face suggest rage and anger in a helpless, low intensity sort of way. His voice is still a bit above a whisper, but somehow, its intensity changes, as he says . . .)* I told them nurses that I can take care of myself . . . they don't believe me, Chaplain, but I can . . . I told them to bring my clothes . . . I'll walk out of here . . . on my own . . . just get me to the bus stop and I will get home . . . they ain't gonna' put me out . . . I'll leave on my own . . . Tell them to bring me my clothes, my sun shades and my beret . . . I'll walk out of this sucka on my own . . . I ain't gonna wait for them to put me out and put me in some nursing home. I'll leave first . . . I'll be back though, me and my lawyer . . . They can't put me out of this hospital . . . just bring me my clothes . . .



TA12= *(I listened a little while longer, as he continued to rave in his anger about them puttin' him out, trying to hear what he is saying, but also, "what he is not saying." So, I decided to go to the office of the Nurse Practitioner and talk with her and some other members of the staff. Also I will read his chart)*

#### Conference with the Nurse Practitioner

Later on in the day, I went to the office of the Nurse Practitioner (NP) to have a talk with her about Da Drummer. She said that Da Drummer is in denial about the severity of his condition and that he is overly optimistic about the possibility of a full recovery. He keeps telling himself that he can take care of himself. The NP told me that Da Drummer had told her that he is capable of taking care of himself. He got angry with her the other day and told her to go get his clothes so that he can get up from out of here. She said that she looked at him like he was crazy. She said that he has a tube going into his stomach, pressure sore on his back, quadriplegia, and that he does not seem to be getting any better. Da Drummer is angry, uncooperative, hostile, and complains all the time about everything. She says that he wants to be in charge of determining the schedule of his patient care. If he keeps on trying to dictate his treatment and oversee his own recovery, he won't be healing anytime soon. In fact he will mess around and end up in a nursing home, with that tube still in his stomach. "I don't think he wants that to happen."

I asked the NP what plans they had for him. She said, "he have got to find a way to get his attention, because he is not making any progress, and he is not listening to us. If he insists on dictating his schedule of patient care, he going to have to get up out of here; and that's all there is to it. He stays angry and upset with the staff. Quite honestly, the staff and I are getting tired of trying to deal with him, and his attitude." She said that they don't

really want to send him to a nursing home. It seems that the whole scenario is a ploy that they are using trying to create a climate for compromise between him and the hospital staff. She said that he has taken the bait and is running with the line.

#### Follow-up to the Previous Conference

On the following day, I approached the NP and asked if they had come up with a solution to the Da Drummer dilemma. She said that, after our conversation the other day about Da Drummer, she decided to go to him and have a heart to heart talk with him. She told him just like it is. She said that she did not pull any punches, but spoke to him open and honestly. She told him that if he insists on calling the shots and determining modes and methods of treatment, they would either send him to his parent's home or send him to a nursing home. The choice is his. Furthermore, if he decides to allow them to call the shots and perform medically proven and time-tested procedures, he stands a better chance of healing properly and increasing the possibility of obtaining a full recovery. But, if he continues to rebel and show hostility towards the staff, he's going to be sent out of here in a New York minute just as soon as they can find a nursing home that will take him. Then too, she said, "maybe a short stay in a nursing home can be a good thing. He may be forced to compare our services with that of a nursing home. He might even begin to cultivate a greater appreciation for what we do here, in terms of the quality of our brand of patient care."

#### Follow up to a Follow-up Conference

The NP and The CN said that they received a message from Da Drummer and went to see him. He had had a change of heart about calling his own shots. He decided to

relent from his previous posture and agreed to be more cooperative with the medical and nursing staff. They said that he did not look them in the eye, but looked away as he talked with them about his change of heart. Since then, Da Drummer has been a model patient.

### 3a. Preliminary Observation - 05/03/2003

As the author entered the room of Da Drummer, his radio/cassette tape/CD player was turned on and the volume was turned up relatively high, probably because it was on the weekend. The artist being featured was Mr. Stevie Wonder. The CD is entitled *Song in the Key of Life*; the track being played was entitled "Always." Da Drummer was grooving to the rhythm of the music. He kept time by moving his head in "an up and down" motion. The author recognized the musical track, remembering some of the words and joined right in immediately, moving to the groove and dancing around the room to the music. Instinctively, the author put down his clipboard, turned and started to "pick and thumb" an imaginary bass guitar and sang along with the track on the CD. Both of us were "gittin' down." The author was dancing, playing and singing and Da Drummer was smiling and moving his head to the cadence of the music. Pretty soon, one of the nurses rushed into the room to take a closer look at what was going on. She said, "Sure is sounding good up in here." She lingered for a minute and then moved on. After the track was completed, the author asked Da Drummer if he could talk with him for a few minutes, and he said, "yes."

### 3b. Verbatim Account // Conversation - 05/03/2003

DD1 = Hey Rev, that was nice . . . I enjoyed that.

TA1 = Yeah man! Kind of brought back some old memories; when I was playing music for a living, back in the day, know what I mean?

DD2 = Me too man (*He is smiling and kind of closing his eyes as he speaks*)

TA2 = Can you move your hands and feet to the beat of the music any at all? Can you feel your hands and feet? What does it feel like to be in your condition?

DD3 = I can feel my hands, but I can't do much with them . . . I can grasp a ball with my right hand, but only for a little bit . . . At first I could not feel my feet. In fact, when it first happened, I couldn't feel anything. Then, on the way to the hospital, the feeling in my hands came back to me . . . Now, I can feel the pain in my feet, when my muscles spasm . . . *(He paused for a moment, looking down towards his feet)* . . . they hurt all the time.

TA3 = How did you feel when it first happened?

DD4 = I felt like I had been hit with a baseball bat . . . It knocked me straight down, and I fell to the ground . . . Then I didn't feel a thing.

TA4 = You didn't feel a thing? *(The author paused for a moment, looking at him intently . . . and said)* What was going on when this happened, and how did you get like this?

DD5 = I was shot in the back and a bullet *chipped* my spine and shattered some of the bones in my back . . . When I fell to the ground, I fell on my left hand and hurt it . . . very much the way it is now.

TA5 = You say you got shot in the back . . . What was going on?

DD6 = *(He pauses and swallows to get air in his lungs . . . he has a tube in his throat area)* I was returning home from a rehearsal when I got in a fight with a young boy in the neighborhood . . . I didn't want to fight him . . . I'm old enough to be his father . . . He's young enough to be my son . . . We started to "dukin' it out" (i.e., fist fighting) and I knocked him out . . . Young boys shouldn't be messing with old men. His older brother was standing on the sideline looking at us fight, egging him

on, when all of a sudden, I knocked him out. When he hit the ground, his older brother drew a gun on me and pointed it at me. Immediately, I turned away from him, trying to get away. Surprisingly enough, he fired the gun and hit me with his first shot. It felt like I was slammed with a baseball bat . . . I went down . . . He had a 357 Magnum pistol . . . The bullet did not pass through my body; it chipped my spine, and remained in my body. It's still in my body. When I first came in the hospital, I was wearing a metallic halo so that I could not move my neck. The bullet is lodged up in my neck, near my spine, close to the back portion of my mouth. Sometimes I think I can feel it at the back of my mouth . . .

TA6 = You mean, you can feel the bullet . . . What does that feel like? DD7 = It doesn't hurt anymore; it's just there . . . I can kind of feel the bullet with my tongue; more than anything it annoys me . . . The doctors are going to go back in there and take the bullet out at a later date . . . They had to pull all my teeth out, because the bullet interferes with the nerves, nerve endings, neural stimulation which sends signals to my gums, mouth and the lower part of my face.

TA7 = Did you know them or have any dealings with them before this happened?

DD8 = Yeah! I knew them . . . They were selling drugs and dealing dope in the neighborhood. They are fifteen and sixteen-year-old boys. Everybody in the neighborhood knows me and knows them . . . um huh . . . The detectives came to see me and told me that they had been sent to prison. He said that they were tried and sentenced as adult offenders . . . um huh . . . The younger one I knocked out got from three to five years . . . The sixteen-year-old shooter got eight to twenty-five in prison . . . I got a lot of friends in the joint . . . These boys will be wearing dresses like little girls before long . . . They think they're tough. They going to find

out what tough really is all about. *(Pausing and musing . . .)* Young men got have something to do to keep them out of trouble . . . Lot of my partners and guys I grew up with are in prison because they didn't have anything to do . . . If it had not been for my music, I would have been in trouble too. I played my music and did odd jobs around the neighborhood like painting, fixing things and so forth . . . When they get out . . . they'll be little sissy boys.

*(About that time, a kinesio-therapist comes in the room . . . pauses for a few minutes . . . standing off to the side, waiting for a convenient moment to interrupt our conversation . . . She asks for permission to start his therapy session while we continue to talk, if it's all right with him . . . he gives her consent. As she is administering therapy, the author said to the patient)*

TA8 = Do you foster any resentment toward the boys that brought this condition upon you?

DD9 = No Chap! I had to move on. I intend to walk out of here someday. I may not ever be like I was, but I'm going to be better off than I am now. I'm making a little progress every now and then, little by little. Nobody can feel it but me, I got to keep on it, stay with it.

TA9 = Well, it looks like you got to start your quest within your own mind . . . You know, I used to do that when I was learning to play the Bass Guitar. I would envision what I was learning to play in my mind and establish it there before I could play it without thinking about it.

DD10 = Yeah, I used to do that too . . . *(Pauses)* I would tune the radio or record player in such a way that the drum cadence would be so low I could hardly hear it. When I could play the tune, stroke for stroke, lick for lick, line for line, break for break,

verse for verse, and not hear the drum cadence in background, then I knew that I had mastered the tune.

TA10 = I can relate to that . . . *(The whole time that we are conversing, I observe as the therapist slowly begins to move his left arm back and forth, in and out, round and round, until she has it almost straightened out. He is deeply engrossed in his thoughts as we continue to talk. The look on her face says that he is doing something that he has not done before, in terms of extending his range of motion with that arm. I chose not to mention it at that time, but just to note it in this case study. I assumed that she has worked with the patient before . . . The physical therapist interrupts our conversation to ask the patient about some bracing devices she needs to execute the next phase of his therapy session. She is too short to see them atop the bureau at foot of his bed. The author reaches up and gets them for her.)*

TA11 = Say man, let me get out of the way, so the therapist can do her work . . . I'll check with you later on . . . Okay?

DD11= All right! *(Pause . . .)* Say Chap . . . Before you go, look over there and find me that Marvin Gaye CD . . . Skip the first two tracks . . .

C12 = Surely! *(The title of the track is: "I Heard it Through the Grapevine." About this time, the therapist has moved to other side of the bed and putting the braces in place on the patient . . . The track is rolling, and the three of us are singing together the first line of the song . . . "Oh // oh, Guess you wondering how I knew // 'bout your plans to make me blue // some other guy you knew before // between the two us guys //you know I loves you more //It took me by surprise I must say //when I found out yesterday. Don 't you know I heard it through the grapevine . .*

*. not much longer would you be mine . . . Oh yeah I heard it through the grapevine . . . and I'm just about to loose my mind . . . hidee, hidee, yeah // Heard it through the grapevine not much longer would you be mine //Baby!). We all shared a good laugh as the Chaplain exited the room and they continued with the Physical Therapy session.*

#### 4a. Preliminary Observation - 07/18/2004

When the author entered the room, there was no music playing; the patient was lying in bed very quietly. He was awake to some degree, alternating between being asleep and being awake. The author greeted him courteously and cordially and he responded in kind. On this occasion, Da Drummer was wearing the braces and harnesses that help to increase the strength, range of motion in his shoulders, the extension of his arms, and the uncurling of his hands.

#### 4b. Verbatim Account // Conversation - 05/04/2003

DD1 = What's up Rev?

TA1 = Not a whole lot . . . Just thought I'd stop by and follow up on that interesting conversation we had on yesterday . . . Okay?

DD2 = Yeah! Rev, that was cool yesterday . . . I enjoyed that myself . . . Yeah . . .

TA2 = When we spoke previously, you mentioned your parents and I presume that they are still alive . . . Do they ever come to visit you?

DD3 = Yeah . . . they are alive . . . No, they don't come to see me . . . My parents are divorced . . . My father left my mother many years ago. He remarried and started another family . . . He has other children . . . My mother remarried also . . .

TA3 = Do you have any brothers and sisters?

DD4 = I have one brother and one sister . . . I am the child in the middle.



TA4 = Have they been to visit with you since you've been in the hospital?

DD5 = Yeah, they have been to see me, but not recently . . . My father has two other children with this other woman and therefore I have a half-brother and a half-sister.

TA5 = Have any of them been to see you?

DD6 = No, Rev, none of my father's family members has been to see me . . . My mother's too old to get out and get up here . . . She doesn't have any way of getting around, much less coming to visit with me . . . That is why it made me mad when they called my mother, and upset her, talking about the possibility of her trying to take care of me, and tricked her into agreeing to send me to a nursing home . . . That ain't right . . .

TA6 = I hear you . . . (*Pausing as he looks away*) You never mentioned any children of your own . . . Do you have any children?

DD7 = No, I don't have any children . . .

TA7 = (*a period of silence . . .*) Are those braces helping you any . . . Can you see any improvement in your strength or your range of motion?

DD8 = No, not yet. I won't know anything until I try to get on my feet . . . Then I'll know for sure . . . But first, I gotta get up out of this bed . . . They are working on these bedsores . . . I heal real fast . . .

TA8 = You say that you're gonna' get up out of this bed? Is that a possibility for you?

DD9 = Listen here, Rev, I gotta think like this. I can't just give up man . . . Understand what I'm saying?

TA9 = I understand, my brother, I truly understand . . . More than you'll ever know . . .

Brother, I wish you well and pray the best for you . . . and if it becomes a reality for you, I ain't mad at you . . . and will not be mad with you . . . (*There is a long*

*pause, as we both look away into the distance . . .) Again, I want to thank you for sharing your life challenges, struggles, faith and hope issues, and life experiences with me . . . I really do appreciate it, my brother . . . (As the author reflects on the faith stance of Da Drummer, the author can remember his own brush with death, and the possibility of being crippled, back in the early 1960s. Only the grace of God caused him to be blessed, to not be numbered among those having to deal with that kind of a physical challenge. The author cannot find it in his heart to speak to him about his desires being unrealistic or to say to him that he is in a state of denial about the reality of his situation and his chances for a full recovery. Maybe the author has the luxury of thinking that from “an ambulatory” point of view. But the author will never broach that subject with Da Drummer because presently that is all that he has to hold onto—the possibility of a full recovery.)*

### **Clinical Pastoral Education Evaluation of Two Cases**

This is a CPE supervisorial evaluation of two cases submitted by Chaplain Cheviene Jones in partial fulfillment of the requirements for degree the Doctor of Ministry, at United Theological, Dayton Ohio. The case studies describe Pastoral Care to two spinal cord injured individuals: a quadriplegic, *Da Drummer* and a paraplegic, *Light Horse*.

I, Cecelia A. Williams, write this evaluation from the perspective of an Ordained Elder in the AME Church and as a Clinical Pastoral Educator at the Louis Stokes VAMC, Cleveland Ohio.

1. *Give feed back of the effectiveness of the variables of pastoral ministry.*

*Reflective Dialogue:* suggested that you have established a good relationship with the patients and accepted them where they are at that point in time. Your use of “self” was effective as a means of reaching out to each of them. You used your personality and life experiences to establish rapport. This was a man- to-man dialogue. You responded to questions without inquiring about the source of the questions or engaging them regarding their frames of references.

You allowed them to use the visitations and dialogue as opportunities to confess their use of drugs without being judgmental or threatening. Your personal self-disclosure let them know that they could trust you with their stories because of your awareness of life and insights for living.

The least helpful parts of your dialogues were your tendencies to become “preachy” and to go on and on with sermonettes that did not appear to connect to their situations. The primary source of power within the dialogues is found in your relationship with them that shares who you are and your understanding of where you’ve been.

*Biblical Interpretation and Medications:* In these situations, the stories of each patient became the “*context*” for applications of interpretations and meditations. Their stories are the hopes for individual transformation and healing. Each story is an operative, sacred, Black, living human document within itself. A Biblical story that may have supported their struggles by way of offering a parallel was: “the demonstration of grace found in the Parable of the Prodigal Son.”

A question that the Chaplain should entertain is: Does your doctrinal approach to biblical interpretation and meditation have a theological framework and/or point of

reference that the patients can agree to? In other words, is this your theology or is it one that is accepted by the patient?

*Prayer.* Prayer appears to be appreciated by the patients. Prayer is a request for healing and deliverance. It is unclear if the patients actively used prayer or any spiritual resources on their own. Nevertheless, the feeling is that the prayer was a healing balm for treatment. Consider what may be done for the patients to incorporate the content of the prayer into their lives in an on-going process.

*Memorization of Bible Verses:* The patients need to have an understanding of what objectives that the memorization of Bible verses serves. Does the memorization of Bible verses invite integration of the word of God or does it become a support to coping with the challenge of recovery?

*Hospital Visitations:* In each visitation, the Chaplain used the power of presence, the power of the pastoral person, the power of positive pastoral regard, the power of acceptance, and the power of the relationship and friendship. The aforementioned elements contributed to the patients' willingness to be confessional and to accept your style of confrontation and friendship. It presents the opportunity for redemption.

*Artistic Therapy and Counseling:* There were two counseling methods utilized in these visitations: (a) Directed, wherein the context of the conversations took form in relation to what was being discussed at the time; (b) Interrogatory, wherein questions were asked mutually for clarity, edification and/or information purposes.

## 2. *How the presence of the Chaplain benefited the patients:*

- (a) The patients' isolation and loneliness were released.
- (b) Hope was installed for the patients
- (c) The patients were personally affirmed in terms of their worth and value.

3. *Tell if and how the role of the Chaplain affected the patients' issues of:*

(a) Anger:

- (i) Legitimized it.
- (ii) Confronted it.
- (iii) Challenged it
- (iv) Instructed them, regarding the danger in harboring anger

(b) Pain:

- (i) The Chaplain acknowledged the patient's physical, emotional and spiritual.
- (ii) The Chaplain instructed about the dangerous bond between anger, pain, and the use of illegal drugs.

Based on the statement, "Light Horse is a lower class individual," the social assessment was weak. This limited a lack of acknowledgment of the essential elements that are needed for holistic care to be offered to the patient. This would include an assessment of his station in life from his family of origin—"where did he start out?" He is an African American Male in a hierarchical society that places him on the bottom rung. Does he have a means of escape? Are there family relationships? What are the strengths and weaknesses of such relationships?

As a whole, these case studies provided a good understanding of how these psychosocial conditions contributed to the patients' struggles with the syndrome of anger, pain and illegal drug usage.

Cecelia A. Williams, D. Min.

Clinical Pastoral Education Supervisor/Chaplain

Louis Stokes VA Medical Center Cleveland Ohio

### Psychological Evaluation of Two Cases

This is a psychological evaluation of two cases submitted by Chaplain Cheviene Jones in partial fulfillment of the requirements for degree the Doctor of Ministry, at United Theological Seminary, Dayton Ohio. The case studies describe ministry to two spinal cord injured individuals: a quadriplegic, *Da Drummer* and a paraplegic, *Light Horse*.

I, Lynne C. Rustad, write this evaluation from the perspective of a psychologist who, remotely, trained on this Spinal Cord Injury Unit, completed a doctoral dissertation there, and served as an SCI staff member for several years.

I was impressed by Chaplain Jones' sensitivity to the challenges facing spinal cord injured patients in the midst of adjusting to catastrophic loss, especially when they have indulged in behavior that may have contributed to their injury. He was sensitive as well to the way in which such injuries change not only the body, but also the life and outlook of affected people and he was able to join with them where they were to facilitate healing. This was especially true in the case of "Da Drummer" where Chaplain Jones was able to use their common language of music to connect with him. Connecting with "Light Horse" appeared to be more challenging and, although Chaplain Jones certainly was able to reach out to him, e.g., through talking about sports, he seemed to preach more and listen less. He felt that this was what "Light Horse" wanted, although that is not so clear from the case study.

Chaplain Jones' understanding of the unit milieu and the importance of the patient/physician relationship also impressed me. His discussion with Dr. Goethe was an interesting addition to the cases. Physicians are often reluctant to discuss their feelings about themselves and their patients and are only likely to do so when in an atmosphere of

trust and respect. That Chaplain Jones was able to connect with the physician, as well as the patients, is a testament to relationships that he had nurtured on the SCI unit.

These cases illustrate very well some of the challenges facing those who minister to patients in such a setting. There is wide variation in religious experiences and beliefs and many patients have become spiritually, as well as socially, alienated. They may not welcome the chaplain's visits and may be quite hostile to the staff members who care for them. An essential element of ministry under these conditions is to breach the barriers with which these people feel they are protecting themselves. Chaplain Jones was able to do this and establish the human connection that is the beginning of healing. But he was able to do more than this. In one case, he helped a patient accept needed treatment. In another case, he addressed spiritual needs.

I hope that Chaplain Jones will write more about his experiences with cord-injured patients. Such work could be helpful, not only to chaplains new to this setting, but could as well provide medical and nursing staff members with a better understanding of these vulnerable patients.

Lynne C. Rustad, PhD

Clinical Psychologist and Bioethics Chair

Louis Stokes VA Medical Center Cleveland Ohio

### **Case Study Evaluation and Analysis for Da Drummer**

This is a Sociological evaluation of a case study submitted by Chaplain Cheviene Jones in partial fulfillment of the requirements for degree the Doctor of Ministry at United Theological, Dayton Ohio.

I, Claude Smith, write this evaluation from the perspective of a Licensed Social Worker and seminary student at the request of Mrs. Earlie Williams, LISW, Supervisory Social Worker at the Louis Stokes VAMC, Cleveland Ohio for Chaplain Cheviene Jones.

I. *Give feedback about the effectiveness of the variables of pastoral care ministry:*

(1) Reflective Dialogue:

a. The Chaplain used the Intervention of Identification as a basis for entering into the patient's space and establishing lines of effective interpersonal communications.

b. The Chaplain used a portion of the principles of Reality Therapy, in the practice of the ministry of presence, in helping the patient to accept some sense of responsibility for his present situation and shunning irresponsible acts of rebellion against the treatment plan for him.

c. The Chaplain helped the patient to confront issues of maladjustment that stems from the presence of Hidden Anger stealthily tucked away in his veneer of being cool and having his emotions under control,

d. The Chaplain helped the patient to continue to hold on to a Vision for the future, a time in which the patient saw himself and getting up and walking out of this Veteran Affairs Medical Center.

I thought that this was an excellent study. The Chaplain used the intervention of identification to draw the patient out of denial and fostered an atmosphere that encouraged him to articulate appropriate responses to questions. The Chaplain's use of methods of clinical intervention was classic in that it caused the patient to be forthcoming about the anger and depression lurking just beneath the surface of his personality and his public persona of self-control.



The Chaplain and the patient shared the common bond of being former professional brother musicians at an earlier time in their lives as a staging area for the development of the rhythm in their relationship. Reminiscing about their past musical experiences and sharing the lyrics and melodies of song common to both of their experiences made it possible for the development of a trusting, mutually beneficial relationship. Therefore, in the reflective dialogue, the patient is clearly disarmed in the presence of the Chaplain and his defense mechanisms do not come into play, in a significant way.

During Chaplain's visitation with the patient, he was able to introduce, and at other times reacquaint the patient with the reality of his traumatic situation and help the patient to make better use of the principles of Reality Therapy. In Reality Therapy, the prerequisite to healing is accepting responsibility for the role that the patient played in the history of the events that acted as a precursor the present situation. In reflective dialogue, the Chaplain and the patient utilized slang terminologies and colloquial expressions, characteristic of the African American experience and of the music industry, to speak in a kind of semi-private manner when other VA hospital personnel were within listening distance. Any fears and skepticisms that the patient had about the Chaplain seemed to have been dispelled when the Chaplain explained to the patient that a fellow musician from his neighborhood, a lead guitar player, had inquired about him, when the Chaplain visited the lead guitar player's business establishment.

Subsequently, the patient was comfortable enough with the Chaplain to share the anger that he felt with hospital staff members who approached his mother about their intentions of placing him a nursing home. The Chaplain allowed the patient to vent his anger. The reaction of the patient to the situation caused his anger to surface and the

monitoring machine's buzzer to be set off. In order to begin the process of addressing the anger, the patient had to deal with the reality of acknowledging that his hidden anger was inextricably tied to unforgiveness and unrepentance toward those who offend him. In many instances, the patient has so much hidden anger and unforgiveness that he needs to be confronted, and resolved. In order for things to work out, the patient had to learn to forgive the offense of others, not only intellectually, but also emotionally. By making use of these things in a professional, yet compassionate manner, the Chaplain was able to "lend the patient a vision."

#### (2) Biblical Interpretation and Meditations:

The willingness on the part of the Chaplain to be open and transparent with the patient helped him to receive the reading and hearing of Biblical Interpretation and Holy Scripture and use it as a tool to help him come to grip with the need to begin the healing process with repentance and asking for forgiveness.

In the case study, the patient's records suggest that he was affiliated the Baptist Church. Apparently, both of his parents were of that orientation, prior to their divorce. Consequently, the patient's roots of spirituality were part of his upbringing. Now in the VA hospital, he was open to accepting some form of meditation based on biblical themes and scriptures.

#### (3) Prayer:

By his own admission, the patient had a belief in God. He turned to drugs to rid himself of some of his pain in his gut and in his emotions. Periodically, the victim would slip back into the world of illegal drug usage. Eventually, he came back and acknowledged that he needed prayer and would eventually start all over again from square one.

#### (4) Memorization of Bible Verses:

The records suggest that he wanted he wanted a King James Version Bible. I believe that the patient memorized some of Psalm 23 and parts of Psalm 46 and Psalm 91, which were read to him, to help him when he was confronted by the demons of Satan. During hard times, when the patient slipped back into the illegal use of drugs, I believe that the reading of Bible verses to the patient enabled him to reach out for help.

(5) Hospital Visitations:

The patient looked forward to the visits of the Chaplain and the sharing of common backgrounds in the nightlife, and adventures with live Jazz and Dance Bands in the music industry in large metropolitan cities. The music became a catalyst for sharing and mutual bonding. Again, the colloquial expressions and slang talk helped to establish a relaxed atmosphere and friendly surroundings wherein meaningful reflective dialogue could transpire between the Chaplain and the patient.

(6) Artistic Therapy and Counseling:

Using their common backgrounds as musicians, the Chaplain used the intervention of identification to make it easier for the patient to identify with him as a fellow musician. The use of the music, the singing of songs, the sharing of lyrics, and sharing tips about mastering unfamiliar tunes helped the patient to relate to the Chaplain as an old familiar friend. From these songs and the implications of the words, the Chaplain could use that opportunity to draw parallels between the lyrics and real life issues. Humor was also a meaningful part of interpersonal communication between the Chaplain and the patient. However, because of the persistency of chronic pain issues, humor was not a consistent part of their reflective dialogue.

II. *Tell how the presence of a Chaplain benefited the patient.*

From my point of view, the relationship between the Chaplain and the patient was primary and the objectives of the case study were secondary. There was a connection between the two of them that made the substance of their conversation have a distinct rhythm or cadence. They were on the same wavelength—kind of the same “vibe.” The ministry of presence can be very beneficial to those who don’t have anywhere to go, just hanging out and being in his room with no agendas and no demand for serious conversation.

III. *Tell if and how the role of a Chaplain affected the patient’s issues of:*

(1) Anger:

The Chaplain was aware of some of the traces of hidden anger still harbored by the patient. The Chaplain allowed the patient to vent the anger that he had directed toward the staff to be re-directed toward him in conversation as it relates to the staff approaching his mother about giving them permission to place him in a nursing home. Secondly, the Chaplain acted as a liaison and/or advocate for the patient with the staff and encouraged the patient to at least listen to the staff’s rationale about the time-line in his treatment plan.

(2) Pain:

It helped the patient to revisit the circumstances surrounding his receipt of the trauma to his spinal cord. As the patient shared with the Chaplain about being able to feel the bullet lodged in the back of his mouth and explained to him that the slightest movement of the bullet could produce sharp pains and great discomfort, the patient talked as if he was revisiting his earlier issues of anger and hostility toward the two brothers that he encountered back in his neighborhood. At that point, the Chaplain was able to raise the

issue of forgiveness as a means of releasing the patient from the excess emotional weight and baggage of his past.

Claude Smith B.S., MSSA

Retired Social Worker, LISW

Louis Stokes VAMC, Cleveland, Ohio

### **Pastoral Care Observation Summary of Da Drumma**

In the Pastoral Care Summary, the author is informed by the evaluations of *the Clinical Psychologist, the Licensed Social Worker, and the Clinical Pastoral Education Supervisor as a Chaplain*. The triangulation of the aforementioned evaluations informs the context of the implications of this four-part summary.

#### *Sociological Implication:*

Da Drummer is a 48-year-old African American Male, Vietnam era veteran in-patient on the Wade Park Spinal Cord Injury Unit, from the City of Cleveland, Cuyahoga County, and from the State of Ohio. He is of the Baptist denomination. He has never been married. His spinal cord injury is the result of a gunshot wound. The patient's disability is not service connected. He is a local musician in the Greater Metropolitan Cleveland Ohio area. As a musician, he probably played an endless string of "one-night" gigs and occasionally two and three night jobs during weekends. I can relate to that kind of a working format. It seems grand, exciting and adventurous in the beginning. But after a period of long lay-offs, canceled jobs, and the local politics and competition in the music business, the romance of being on stage and in the spotlight fades and the reality of the inconsistency in your cash flow, and fewer good paying jobs can cause a man to look for alternative forms of employment. Da Drummer stated that he was a member of the local

musicians union and also possessed a cabaret card. The possession of these cards suggest that *Da Drummer* could read sheet music and therefore perform charted musical arrangements with a minimum of advanced practice. Nevertheless, he was a neighborhood handyman who performed odd jobs for the homeowners and tenants in his community. *Da Drummer* is probably a lower class individual with no steady job and no steady income. This is characteristic of most local musicians. Only a small percentage of them make it to national prominence and recognition.

*Psychological Implications:*

The quadriplegia of *Da Drummer* is the one of several factors that cause him to try and keep himself and his emotions under control. From a psychological perspective, the patient seems to have a smooth and even-tempered demeanor. In the music industry, we call it maintaining your "cool" at all cost or "never let them see you sweat." However, underneath this calm veneer of psychological serenity, there is unresolved anger, anxiety, bitterness, loneliness, grief, sorrow, isolation, and abandonment. Because of the traumatized condition of the patient, many of his personal issues have not been properly addressed. The patient states that he has forgiven the person(s) responsible for causing him to be in his present condition of quadriplegia. Furthermore, he speaks of having accepted his plight in life as a quadriplegic and of harboring no ill will towards his young assailants. Nevertheless, he finds the strength to speak of getting up out of his bed of affliction and walking out of this hospital someday. The patient speaks of the necessity of thinking positively, even in the midst of his traumatized circumstances. The patient said: "What has happened is a thing of the past . . . this is what I'm left with. I can't understand it . . . but I can 't just give up or give in. I've got to make the best of it." The staff says that he is in denial about the possibility of a complete recovery. The patient said that he is

not in denial about his potential for experiencing a full recovery. This is the mindset he must maintain in order to persevere and to keep progressing and thereby have a reason for living. The medical, nursing, and psychological professionals think that the patient is in denial because he is not accepting their diagnosis and prognosis for his future health. They say that his expectations are unrealistic and unattainable. As a Chaplain and as an observer juxtaposed between the patient and the other members of the interdisciplinary team, the author can see the perspectives of both sides. The author understands the logic and critical analysis of scientific medical investigation, but the author also understands the position that the patient must take for the sake of his own sanity and his own peace of mind. As a Chaplain, the author will not encourage him to be irresponsible or to embrace rebellion. But if it is the decision of the patient to take the road of faith in treatment and/or believe in God for the miraculous, to journey down the "less traveled" highway of hope, the author must find a way to be as supportive as he can through practicing the ministry of presence in such a way that it does not distract the patient from seriously considering the concurrent reality of the scientific medical perspective.

*Spiritual Implications:*

The patient's records say that he is part of the Baptist Church, although the author doubts if he was actively involved in the life of the Church at the time of his trauma. More than likely, his spirituality and passion are wrapped up in his love of music. This expression of spirituality, self-esteem and self-worth has been wrested from him through the savagery of a gunshot wound. This patient is fighting for his spiritual life minus the talent/gift that he coveted for himself. Things psychological and things spiritual are intermingled and intertwined in the life of this patient because his music is also his passion and a primary source of his identity. The patient exhibits subtle anger toward God because

of his quadriplegic condition and has often posed the following rhetorical questions to God: “why me, why this, and why now?” Furthermore, there is the guilt and shame associated with having to explain his condition to the curious, the inquisitive and the nosy people of the world who look at him with the judgmental eyes of pity and no respect. Additionally, they might ask the question that lays the blame at his feet. “What were you doing that attracted this terrible thing to you? Has God abandoned you? Have your sinful deeds finally caught up with you?” To some degree, this patient has pushed past most of this excess baggage and dares to reach beyond his spiritual reach hoping that positive thinking, and spiritual confirmations will make a difference for him as he attempts to acquire the desires of his heart, that is, to get up, be well, and walk out of this hospital in his own strength and under his own power. The author is determined to give him all the spiritual support that he can muster without taking over and making decisions for him. He must be given the opportunity to make up his own mind, beginning in faith and continuing in hope towards a realization of his desires.

*Self-Evaluation:*

As a Chaplain, the author ministered to *Da Drummer* with a great sense of empathy, informed sympathy, respect and compassion; because, but for the grace of God, the tables could have been turned. The author could have been either a paraplegic or quadriplegic. From all accounts of the author’s automobile accident, he teetered on the periphery of paraplegia or quadriplegia and had a close brush with death at that time. A matter of inches, one way or another was the determining factor as to whether the author escaped paraplegia/quadruplegia or whether paraplegia/quadruplegia consumed him. The author is blessed to have a testimony that Father God extended favor towards him. He spared the author the experience and shielded him from peril and danger through His Son



and Lord, Jesus Christ. To be sure, it really could have been the other way around. *Da Drummer* could have been the Chaplain, visiting him; and the author could have been the quadriplegic wearing the harnesses and braces as the author lay in a hospital bed. The author could have been asking the questions, “why the author and not him?” or “what did the author do to displease God?” It could have been the author having to make the decision to walk the walk of faith, in spite of his understanding of the accuracy and precision of the diagnosis and prognosis of the members of the interdisciplinary team. The author’s reflections suggest there were some decisions that the author made about his treatment that went against the recommendations of his doctors. The author didn’t make a big issue of it verbally, but in the quietness of his mind, the author made a few decisions based upon his faith in God and the truth and dependability of his word, which flew in the face of the doctors’ and nurses’ treatment plan. The author practiced the ministries of presence, empathy and compassion, and utilized the cultural relevance of ethnic anecdotes in the communication process to “break the ice of unfamiliarity, and to get into the flow” of comfortable, meaningful dialogue with the patient. The author used several colloquial expressions, slang terms, and jokes at various times for the purpose of establishing rapport and keeping the lines of communication open on various levels. The author listened to the patient attentively. The author was alert and responsive to changes in moods and emotions and showed compassion and respect towards the patient. In some instances, the author led their conversation in a certain direction to some degree based upon the tone, tenor and dynamics of their conversation, yet the author allowed the patient to vent his anger, frustrations, fear and anxiety, as the patient saw fit and followed his lead as he revealed his story. Music, musicianship and nightlife culture were the common denominators and bases

for the blending of our personalities and the sharing of information. The author was comfortable with the story of the patient, his friend, *Da Drummer*.

Before the author could conclude the business of this case study, Da Drummer died in the month of August 2004 in a nursing home. In reminiscing on the content of our conversations together and the bond that we established as brothers, there was one request that Da Drummer made that the author regrets he did not perform. At the height of his expression of anger toward the staff when they first started planning to send him to a nursing home, Da Drummer asked the author to bend down so that he could whisper in my ear. This is what he said: ["Hey Chap, I want you to do something for me." (*and I said . . .*) sure man . . . What is it?" (And he said . . .) Chap they think I can't take care of myself . . . I'm gonna' show them something . . . I'm gonna show 'em . . . here's what I want you to do . . . I want you to get me a pair of *red shoes*, and place at the foot of my bed . . . and in the dark of night, I'm gonna get up out of this bed, and get dressed, and walk out of here . . . but I need your help, I need your help.]

The author regrets not having brought Da Drummer that pair of *red shoe*. The author should have done it. Who knows, the presence of the *red shoes* might have been the catalyst for his faith to make a giant leap across the chasm of spinal cord injury trauma. The author was caught between the horns of a dilemma: between the medical scientific evidence of his condition and yet desiring to assist *Da Drummer* in his need of the object of the *red shoes* to make an existential leap of faith. As the author recalls the incident, it happened toward the end the week. During the following week, for whatever reason, the author did not follow through. If he had it to do over again, he would get a hold of a pair of *red shoes*. Who knows, it might have made a difference. In the future, if ever a question

of faith arises that places the author between the horns of a similar dilemma, without hesitation the author will find a proverbial pair of *red shoes*.

### A Case Study of Light Horse

Resident Student: The Author      CPE Supervisor: Dr. Cecelia A. Williams

Date of Case Study: 04/02/04 to 06/17/04

Date of Interviews: 04/15, 04/22, 05/03/2004

Location of interviews/study: WSCI    Interviews/studies numbers: 1 to 5

Interview number: 1, 2 & 3      Patient pseudonym: Light Horse

Patient age/sex/race 48/Male/AA    Patient disease Paraplegia - Auto Accident/Gun shot

Religion: BAPTIST      Length of Visit: From 30 to 45 minutes

#### 1. Background Information

Light Horse is a 49-year-old African American Male, Vietnam era veteran of United States Army, an inpatient from Youngstown, Ohio. He is of the Baptist denomination. Presently, his parents continue to reside in Youngstown Ohio. There are other siblings. Visitation is infrequent. During Military service, Light Horse served in the United States Army. His Military Operation Specialist (MOS) was that of a "Quartermaster." He was married previously and at that time they were members of a Christian congregation in Texas. His spinal cord injury is the result of both an automobile accident and a gunshot wound occurring in Houston, Texas. The patient's disability is not service connected.

The author became involved with the patient as a result of making an initial visit to the patient's room when he was processed into Louis Stokes VAMC environment to address some medical issues and minor surgical procedures. The pseudonym, Light Horse,

was the nickname of an All-Pro Defensive Back of the Old Saint Louis Cardinals of the National Football League. Because their actual names are similar, the author and the patient decided to use the football player's nickname as the pseudonym for this patient.

2a. Preliminary Observation - 04/15/2004

Upon entering the room, the author found the patient sitting in his wheelchair. Light Horse whirled around using both his arms and hands to address and converse with the author. Light Horse's mobility suggested that he was a paraplegic who sustained an injury to the lower part of the thoracic or the lumbar areas of his spine. His chart suggested that he had a bullet lodged in his spinal cord. He had not long been in his room and was yet to put any of his personal things on display in his room.

2b. Verbatim Account // Conversation - 04/15/2004

LH = Light Horse, and TA - The Author.

TA1 = (*I knocked on the doorframe, and entered into his room saying . . .*) Good afternoon Sir! I am Chaplain TA, speaking to you . . . Welcome to the Louis Stokes VAMC. I am the Chaplain Resident assigned to this Spinal Cord Injury Unit. If I can be of any assistance to you during your stay, please don't hesitate to call on me.

LH1 = Yeah Chaplain, as a matter of fact, I would like to have a large print Bible, preferably a King James Version.

TA2 = I'll check in the supply room after I complete my rounds. If we have it, I will surely bring a copy to you in the near future . . . (*The Chaplain paused for a moment and said . . .*) I see you are wearing a Dallas Cowboy hat.

LH2 = Yes, that's my favorite team.

TA3 = My brother, you got good taste in your choice of a football team . . . Are you a recent fan?

LH3 = No! I started following them when I lived in Houston, some years ago.

TA4 = You lived in Houston? Why not the Oilers? They had a good team with “brother” Warren Moon at Quarterback.

LH4 = I don’t know, I just liked the Cowboys better . . . HOW ‘BOUT THEM COWBOYS . . . That’s what Coach Jimmy Johnson use to say.

TA5 = Yeah! My man, How ‘bout them Cowboys . . . I’m an old school, long-time Cowboys fan. I go back to the days of Dandy Don Meredith, Craig Morton, and Roger Staubach at Quarterbacks, Don Perkins at Fullback, Tony Dorsett and Calvin Hill as Halfbacks, Pettis Norman at Tight End, Drew Pearson, Bob Hayes and Tony Hill as Wide Receivers, Rayfield Wright at Offensive Tackle (*my home-boy*), Bob Lily and Jethro Pugh at Defensive Tackles, Ed “Too Tall” Jones and Harvey Martin as Defensive Ends, Leroy Jordan, Randy White and Hollywood Henderson at Linebackers, Utility Man, Preston Pearson, Defensive Backs, Cornell Green and Bill Bates, under the leadership of Coach Tom Landry wearing that funny-looking little hat. (*As we are laughing and whooping it up, as we reminisce*)

LH5 = I like the Jerry Jones/Jimmy Johnson version of the Cowboys better, Troy Aikmann, Emmitt Smith, Deion Sanders, and that awesome offensive line that they more recent Cowboys greats introduced to the modern NFL . . .

TA6 = I think that Jimmy Johnson was a great judge of talent and also a great Coach. He seems to have mastered the art of being able to reach inside the psyche of the Black Athlete and get him to perform at a high level of excellence for an extended

period of time . . . How 'bout them Cowboys . . . You mentioned that you lived in Houston. Is that where you were in the Army?

LH6 = No! That was where I got hurt and disabled. I was stationed at Fort Riley Kansas.

TA7 = Fort Riley Kansas . . . What was your MOS (i.e., Military Operations Specialist)?

LH7 = Seventy-Six Charlie.

TA8 = Seventy-Six Charlie . . . and that is . . .

LH8 = Quartermaster.

TA9 = Quartermaster . . . Oh yeah! You pack the stuff up, huh?

LH9 = I pack it . . . I get 'em ready to get out there in the field . . . ha, ha, ha, ha

TA10 = Ha, ha, ha, ha . . . Yes Sireee, my brother . . . And ah, were you . . . ah did you have a problem with your leg while you were in the service?

LH10 = No! I never had a problem with my leg. I was very healthy in the service. This happened after the service.

TA11 = Was this result of Diabetes, or . . .

LH11 = No! I lost my legs, ah, in a car accident

TA12 = . . . in an accident

LH12 = Yeah! And I got shot . . . all this happened at the same time . . .

TA13 = Oh really! Was someone shooting at you . . . was it an accident or was it intentional?

LH13 = They were shooting at a friend of mine, but they ended up hitting me

TA14 = Oh! I see; I see . . . So . . . you were kind of . . . along for the ride . . . and got shot.

LH14 = Exactly . . . and I got shot.

TA15 = What was he doing . . . Was he a thief or something?

LH15 = Yeah . . . I think he was trying to rob this guy of some drugs . . . it was in a bad, drug infested neighborhood.

TA16 = . . . in Youngstown?

LH16 = . . . in Houston, when I live in Houston.

TA17 = . . . in Houston Texas?

LH17 = . . . in 1988, August 12<sup>th</sup> . . .

TA18 = . . . Were you using illegal drugs at that time?

LH18 = Exactly . . . I was along for the ride

TA19 = . . . along for the ride . . .

LH19 = . . . I didn't know what he was doing . . . I wasn't a part of that . . . if I had known that, I wouldn't have been with them . . .

TA20 = . . . uh huh . . .

LH20 = It was me and his sister in the back.

TA21 = Were you angry with him for a while?

LH21 = I'm still angry at him . . . he changed my life around . . . permanently.

TA22 = . . . You do understand that part of the whole process of healing has to do with releasing that anger.

LH22 = Yeah . . .

TA23 = No matter what it is now, whether you got hurt by accident, whether the shot was meant for you, or you got it because someone was shooting at him . . . you got to release the anger . . . because the anger is a spirit that affects your mind, your body and your health . . . it also has to do with the way you process information. Anger . . . and in addition to anger comes the pain. And then . . . ah . . .

LH23 = . . . Do you mind if I take notes?

TA24 = No problem, at all . . .

LH24 = Anger is pain, you said . . .

TA25 = No! No . . . With the anger comes pain . . . Because, if you realize now . . . when you are angry, what happens to your mouth?

LH25 = . . . it frowns up . . .

TA26 = Also, you grit and grind your teeth together, clench your fists . . . these are all abnormal things to do . . . Your body is not at rest . . . you've entered into a fight mode . . . you know . . . Ah . . . You see . . . anger, itself, causes a response within the body . . . and because of the emotions, you see . . . your body can be in an emotional fight mode all the time . . . and if you don't release it, the adrenaline glands can be attempting to perpetuate your desire to be angry . . . all the time . . . or either to get a hold on the one who carried you into the place that you got hurt and got shot . . . Nothing happened to him that night, huh?

LH26 = No Sir . . .

TA27 = Did he get shot?

LH27 = No; he did not . . .

TA28 = So . . . he was the reason for you being there . . . and you were the one who got shot . . . Did his sister get shot?

LH28 = She didn't get hurt . . . She was crying because her car got some holes in it . . . I told her to . . . fuck her car, you know . . .

TA29 = Yeah . . . you got holes in your body.

LH29 = Exactly . . .

TA30 = uh huh . . .



LH30 = I thought I had been hit more than once . . . but I know that I got hit in my spinal cord . . . the bullet is still lodged in my spine.

TA31 = Is it still in there?

LH31 = It's still in there . . . they could have taken it out, but they didn't want me to not be able to use my arms and hands . . . If they had taken it out, they might have bruised in such a way that my hands could have been frozen in a crooked up fashion . . . cause, I've seen people like that . . . They can't even open their hands up. They didn't want to risk it . . . which I appreciate . . . (As he is sitting in his wheelchair . . . he opens his hands and gestures as he says . . .) You know, it's uncomfortable and very painful sitting like this . . . you got a bullet in you . . . then you got to worry about lead disease . . . I got a lot of people look at me and say, I couldn't live like this . . . (With his arms spread wide, his palms up, and his hands open). But they don't know . . . until you have walked in my shoes, you don't know what you can tolerate.

TA32 = This is the hand that . . .

LH32 = My hands are my feet . . .

TA33 = I understand that . . . I also understand that this is the life that has been dealt to you . . .

LH33 = This is how my cards have been dealt to me . . . and ah . . . I'm not giving up . . . 'cause God's going to take me out of here anyway eventually . . . but . . . using drugs is not a good thing for me either . . . but I do that (drugs) to escape . . . I use it like an escape route . . . you know . . . but I shouldn't do it . . . and one day I pray to God that I will get rid of it and live on God's terms, you know . . . and I feel like it's coming very soon 'cause I'm tired, you know . . .

TA34 = Well, my prayer for you will be that if you release the anger and release the man who caused the problem . . . ah, that you will find an opportunity to give God the anger, the pain, and also give him the illegal drug usage, that whole syndrome. Our prayer will be is that God will give you peace in your body . . .

LH34 = . . . Peace in my body . . . I like that . . . peace, I need peace.

TA35 = Yeah . . . and also, peace in your mind . . .

LH35 = Peace in my mind . . . peace in my mind . . . I like that also, as well.

TA36 = Because, in the process, with illegal usage comes loneliness, depression . . .

LH36 = I'm not suicidal though.

TA37 = I know that . . . but ah . . .

LH37 = Peace in my body you said, right . . .

TA38 = Yeah, uh huh, yeah . . .

LH38 = But what about the pain, I'm dealing with?

TA39 = Well now, the anger and the pain are attached to each other.

LH39 = What about the bullet in my spine?

TA40 = The Lord can even give you victory over that now.

LH40 = Will I be able to stop taking pain medicine?

TA41 = We don't know that. It might even be the case one day. But right now, we don't know that . . . We know that you take a regularly scheduled regimen of legal drugs all the time, don't you?

LH41 = Yeah, you're right . . . once a month, I get drugs for the whole month.

TA42 = Because Dr. Murphy sends you legal drug from the VA, right?

LH42 = Uh huh . . .

TA43 = Dr. Murphy does . . .

LH43 = Right . . . that's for my back.

TA44 = Yeah, that's for your back . . . and that's also for pain too, right?

LH44 = Exactly.

TA45 = Also, those prescriptions have to do with keeping down your infections with antibiotics . . . a regimen of antibiotics and painkillers, right?

LH45 = Right.

TA46 = Ok . . . Because, you have to do something to counteract that lead poisoning, like you said, right?

LH46 = Question . . . When you got lead in your body, it's not a good thing, is it?

TA47 = No! It's never good . . . You have a certain amount of lead in your body, anyhow, because we have traces of all kinds of metals and minerals in our bodies, but at very low levels . . . But at the place that the lead bullet is located in your body, I do not know the degree to which it is being absorbed.

LH47 = The bullet is located at vertebrae T- 6.

TA48 = Yeah . . . I know . . . it's located in the thoracic area . . . And you still have feeling, mobility and a full range of motion, with the movement of your arms and hands, above their relation to your spine is above the T- 6 vertebrae, right?

LH48 = Right.

TA49 = Right . . . because in everything below vertebrae T- 6, you lose feeling and mobility.

LH49 = But I'm not fully paralyzed, I'm partially paralyzed.

TA50 = I know . . . Because if it were up in the Cervical area

LH50 = Oh . . . If I got hit in my neck, I'd be through . . . I wouldn't want to live . . . I wouldn't want to live, man . . . I hate to say that, because I love life . . . But when

you got somebody wiping your ass, doing everything for you, washing you . . .

You see, I can do all of that myself. I can go in the bathroom and take a bath and all that; I can do everything but walk. And that's why I don't understand why I do drugs, you know, because I can do things other people can't do. I shouldn't do that, man; I'm going to seriously pray on this and get away from this. I don't need this.

TA51 = Let me tell you this . . . the anger ties you to the auto accident/gunshot event and the man who caused you to have that experience . . . What's his name?

LH51 = His name was Jersey . . . I don't even know if that was his real name, I didn't know the guy that well.

TA52 = Regardless of what his name is, you've got to release him and also release that anger. It is the anger that causes you to remember who he is and also causes you to relive that moment in a vivid fashion time and time again. It is a spirit that stays in your mind and it is also a spirit that follows you. It is a spirit that took advantage of you and of your mind when your physical body was in a weakened state of emergency and shock. The influence of anger, pain and the feeling of being lonely promote feelings of being less than a normal man, feeling like you've have lost out, that you've been diminished, physically, and sexually.

LH52 = I feel like I've been cut short of being a man, you know . . .

TA53 = Uh huh . . . How about your sexual experience?

LH53 = The only time I mess around . . . Can I call you Chaplain?

TA54 = You can call me that if you want to . . .

LH54 = The only time I mess around is when I'm doing drugs . . . Then I can pay for, get it over with, you know, I don't have to wine and dine a woman . . . I'm being real

with you . . . I'm keeping it real . . . that's the best way to go . . . be honest. That's the only time I mess with a woman. If I am not doing drugs, I don't mess with a woman because I feel as though I am inadequate, per se, I can't screw her the right way, excuse my French. Then I don't want no woman to see me with no legs, you know, can't do too much. But if we are getting high, she'll tolerate me and I will tolerate her because the money is involved and the drugs are involved. She's getting something out of it. I 'm getting a little something out of it, you know. And that's the way it goes. But you know; it could be better than that. I don't have enough of nobody like that and it's going to stop. I really don't want a woman like that, under those circumstances, man. She's using me, and I'm using her. That is not the way it supposed to go. So before I got put in this chair and lost my legs, I had real relationships. I was married for eight years. I had a nice wife; we were in church. But I slipped and she ended up leaving me because of my slipping, you know . . . I'm trying to get myself together . . . I am not ready for anybody. *(There is a gradual pause and a moment of silence . . . then the Chaplain says . . .)*

TA55 = Anger, pain and illegal drug usage. We already know that you have the givens of the antibiotics and the painkillers. Let me ask you this question: what happens, when you take the pain prescriptions. Do they remove the pain, dull it; or does it go away?

LH55 = It stops the pain to some degree. I have a numbing sensation in my body before I take the painkillers and I have a needle and pinching sensations in my back. I have sharp pains in my back. I think it's because of the bullet and my spinal cord injury. It's all tied together. It's painful. When I take the pain medicine, it relieves me for a little while, but it comes back.

TA56 = How long?

LH56 = A couple of hours, two or three hours, maybe. I only take one at a time. Dr.

Murphy told me to take them as needed. Don't take them altogether, like one or two at a time. I scared of pain medicine. I think people take and then drink alcohol, and many instances they die. You can't mix medication with alcohol. That's one thing I will not do; I will not play with that.

TA57 = So, a fear of death is behind that too . . .

LH57 = Yeah, there is a fear of death in me. If you slip up while trying to party with them, taking medicine and alcohol, they can hurt you. Pain medicine and alcohol do not mix.

TA58 = What about illegal drugs, do you mix alcohol with them?

LH58 = Are you talking about smoking CRACK?

TA59 = Well, yeah!

LH59 = Yeah, I do . . . and that can kill you.

TA60 = Apparently, you don't think about death when you smoke CRACK!

LH =60 Well, when you are partying, you mind is in a different dimension, and ah, and I'm trying my best to get away from that.

TA61 = You once mentioned that, certain girls show up when your monthly check arrives . . . that they show up when the check comes . . .

LH61 = Right . . . right . . . they don't show up, but they'll call me

TA62 = They'll call me . . . uh huh.

LH62 = And they'll ask me, if I want to see them, or do I want to party . . . That's why I think I'll do better in a nursing home because I'll develop clean time because I won't be around nobody doing drugs, I'll keep my nose clean . . . When they come

over to see me, they take all my money . . . but I don't care about that anymore . . . I'm looking at my life . . . I'm trying to prolong my life . . . and stay on the straight and narrow . . . That's what I'm about right now. What I have done in the past . . . is in the past, it's about right now . . . God only gives us one day.

TA63 = . . . at a time . . .

LH 63= . . . uh huh, and I'm determined to try to live my life right.

TA64 = . . . a day at a time. We only have one life . . . lived one day at a time

LH64 = That's right . . . I've done some bad things to my body man, you know. It goes back to what you said, Chaplain, about being lonely . . . you know . . . what I told you about being lonely. I'm just a dude in an apartment you know. I'm tired of that apartment, you know . . . I'm tired of being there.

TA65 = What's wrong with it?

LH65 = Well, I'm not going to blame the residents where I live . . . but a lot of people . . . well, people talk, you know; and I gave my 30 day notice and stuff . . . I want to move on . . . it's time for a new beginning. I live in Cuyahoga Falls. If I could move to Cleveland . . . that would be fine . . . but ah, I can't pick up the same habits . . . because you can go to Cleveland and get in the same stuff.

TA66 = That's true . . .

LH66 = More of it . . . That's right . . . So, you got to have a clean and a sound mind, and that's why when I go to a nursing home, I will be able to get me some "clean time" developed.

TA67 = You keep saying clean time . . . What do you mean by the expression, "clean time"?

LH67 = "Clean time" means no drugs!

TA68 - Ok, so the whole period will be "clean time."

LH68 = Exactly . . . Then when I get out, I'll have some time to work with. I'll know that I've been good . . . you know . . . maybe I will have stayed in there six months to a year . . . I'm 47 years old now; you know what I'm saying, I am not getting any younger . . . I'm tired of messing around with this shit.

TA69 = When I called you from home, the other day, someone answered you. He said that you were doing volunteer work.

LH69 = *(There was a long silence, as he hung his head down, and kind of rubbed his hair, with the ball of his fingers . . . then he said)* That was me . . .

TA70 = Huh. . .

LH70 = That was me . . . to be honest with you

TA71 = That was you?

LH71 = Yeah . . . I lied . . . I was busy cleaning up and stuff.

TA72=Ok . . . Well I . . .

LH72 = I hope you ain't mad at me

TA73 = I ain't mad at you, my brother . . . How am I going to be mad at you?

LH73 = I just want to be honest with you.

TA74 = I thank you . . . You know, one of the things that I enjoy about being around the hospital is that I have a cordial, informal relationship with the patients. They are honest with me, most of the time . . . and I am honest with them.

LH74 = Chaplain, do you know anything about the domiciliary program at the Brecksville facility?

TA75 = Yes I know a little bit about the Brecksville program. One thing is sure, it might not fit your needs though because it only lasts about six weeks at the most.



LH75 = They don't keep patients a long time any more? They used to stay up there for a year.

TA76 = Well . . . it could last, I don't really know about that. You'll have to talk to Doctor Murphy about that . . . because the last I heard . . . they are getting ready to close that facility out there.

LH76 = Yeah . . .

TA77 = They are going to close that facility and build a replacement facility near the Wade Park Hospital location.

LH77 = Ah . . .

TA78 = They are going to close Brecksville . . . But before I leave, we can call Doctor Murphy's office and talk to him about the domiciliary . . . for a short term stay.  
*(There's a long pause, as he seems to be weighing his options. Then the Chaplain asked the question)* . . . Who's going to do your surgery?

LH78 = Doctor Staphona has enlisted Doctor Peterson, I think.

TA79 = It's not a VA Doctor, right?

LH79 = No, it's not a VA Doctor.

TA80 = Ok . . . Well, ah . . . Marianna West, the Social Worker . . . I can't think of her telephone number. Also, there's a Social Worker whose last name is Turner up there too. Marianna West just might have the information necessary to address your concerns about the Brecksville facility . . . *(The Chaplain retreats to a previous concern earlier in this visitation/consultation)* . . . But before I leave, I want to stress the fact that the anger and the pain have become associated . . . they are attached to each other. And the intensity of the pain can persist in direct proportion to the degree that you experience anger, even when you are not even

conscious of it. Anger is very much like certain venomous snakebites. If you don't get the venomous poison out, it will make you sick and/or it can eventually kill you. The poisonous venom can attack you . . . in your nervous and/or muscular systems.

LH80 = (*The patient pauses . . . and looks at me as says . . .*) You know, I'm tired of people using me, you know . . . I get them opportunities . . . I give people money, they take off . . . come back . . . they wouldn't do that somebody else, unless they are dealing with someone like me.

TA81 = Yeah . . .

LH81 = It's a lot of things just like you said, anger and pain, it goes back to that. It all goes back to that.

TA82 = Loneliness

LH82 = Loneliness

TA83 = Rejection

LH83 = Rejection

TA84 = Abused

LH84 = Abused

TA85 = Misunderstood

LH85 = Misunderstood

TA86 — Misused

LH86 = Misused

TA87 = Devaluated

LH87 = People talking about you.

TA88 = Being misunderstood, that being talked about. (*My telephone rang to interrupt the flow of our conversation . . . then we continued*). I know for a fact that I have some problems with anger and I began to realize it even more, while I have been working at the VA Hospital that I had latent anger . . . When I was in college, I was in a very bad auto accident. It was only by the grace of God that I did not become a paraplegic or quadriplegic. During visitations, I became aware of the fact that I identified with patients on the Spinal Cord Injury Unit more than I did with patients in other parts of the hospital. I know that the guys who had accidents before me and after me were either partially or totally paralyzed and their bodies were traumatized.

LH88 = A lot of them use drugs too

TA89 = I know . . . and they use drugs to relieve themselves and also to escape without leaving the scene. Since they can't walk away from the place, they can change their attitude and their context of existence. Through the use of illegal drugs, they are allowed to be there and yet not be there or at least have a different relationship with themselves.

LH89 = Drug addiction covers a lot of people.

TA90 = What it also does is this . . . It also causes synergy problems with the regimen of prescribed drugs of antibiotics and painkillers.

LH90 = Uh huh . . .

TA91 = And the bottom line is . . . that pressure sore which you have that won't heal . . . you do know that the illegal drugs complicate matters, and makes it impossible for you to heal properly.

LH91 = Smoking has the same effect.

TA92 = Exactly.

LH92 = Doctor Murphy said not to smoke; that it would prolong my healing process.

TA93 = Exactly . . . Because in your case, you have the illegal drugs acting on your body, the pain killers acting on you body, and you got the lead from the bullet acting on your body. Additionally, signals from your brain are confused and being distorted before they can ever reach the extremities of your peripheral nervous system because the lead bullet rests upon your spinal cord.

LH93 = Exactly.

TA94 = In the meantime, when you move in a certain way, it causes you pain because the nerve endings are so sensitive where the bullet is lodged in your spinal cord.

LH94 = Right.

TA95 = And if the doctors were to remove it, you might end up deformed.

LH95 = There are many guys right here in the VA hospital that can't move their hands simply because doctors tried to dislodge a bullet from a traumatized spinal cord . . . After all is said and done, I think I'll be better off in a nursing home.

TA96 = You think you'll be better off in a nursing home?

LH96 = . . . For a little while . . . until I get my mind straight.

TA97 = Ok . . . Clean environment.

LH97 = Clean environment, no drugs, no smoking

TA98 = No coffee

LH98 = No, I drink coffee . . . Is that bad for you too? I'm being honest . . .

TA99 = (*Chaplain laughs a little bit*) Do you know that one of the drugs that they use as anesthesia is caffeine? Caffeine, in its natural state is so strong that it'll knock you

right out . . . So, when I'm trying to get myself straight, I don't drink coffee . . . I quit smoking years ago . . .

LH99 = Good . . . Did you ever use illegal drugs?

TA100 = No, I've never used illegal drugs

LH100 = Did you ever drink alcohol?

TA101 = Over the years, I have used alcohol from time to time, but never to the extreme . . . Occasionally, I will have a glass of wine, here and there, or with a dinner meal . . . but nothing regular . . . I smoked marijuana once, but it didn't do anything for me . . . nothing happened to me . . . I smoked a whole bag.

LH101=Wooooo!

TA102 = Uh huh.

LH102 = A whole bag?

TA103= A whole bag . . .

LH 103= By yourself?

TA104 = Uh huh . . . By myself

LH 104 = Damn . . .

TA105 = I sat down in a chair and waited for the high . . . but nothing never happened.

LH105 = I know that you were plastered!

TA106 = No, I wasn't . . . I was with the members of my Band, called "the Prime

Ministers," my partners. They sat up and waited with me. I was looking at them and they were looking back at me. They were just waiting for it to all come down on me so they could laugh at me, but nothing happened.

LH106 = Did you ever used cocaine?

TA107 = NO, I never used cocaine . . .

LH107 = Good, man, that's a blessing . . .

TA108 = However, I was very much sexually active . . . Sex can be a drug in and of itself.

LH108 = Yeah, it is . . .

TA109 = That's an addiction too!

LH109 = It's ironic that you should bring that up, because . . . I think I got a sexual problem too. Do you know why?

TA110 = Why?

LH110 = Every time I smoke CRACK, I throw an X-rated movie into the VCR . . . I can't smoke it without, looking at the movie with Black women or White women, and Black men and/or White men having sex . . . I think I got a sexual problem . . . I think I need to address that as well . . . along with the anger and pain . . . So, I'm trying to cover all of that, you know . . . Because, if you don't ask for help; you won't get help.

TA111 = Ok.

LH111 = You won't get help . . . You'll continue to prolong this . . . continue to do this dumb shit, you know, getting high . . . having people use you . . . and you using them . . . And no, you don't ever get "nothing" out of it . . . That's why I want to address all of this anger, pain and my sexual problem . . . all that, man . . . Because all of that's got to come to an end.

TA112 = Well, let me tell you something . . . One thing that I've found out is that when you approach a problem or a series of problems, you've got to understand one thing. There is a distinct advantage in approaching these things from a scriptural frame of reference for this reason. The advantage that you have is that "a mortal man is not responsible for what is written in the Holy Scriptures." If a man was

responsible for what is written in Holy Scripture, the words would not be able to heal you by what it has to say; even if he was holy. Scripture written by a mortal would not be able to make you feel better by meditating upon it, learning it from memory, or rehearsing it repeatedly. It can only work for you if Father God is the Author and Composer of the word(s) and it was mediated through God's first and only begotten Son, that is, Jehovah/Jesus Christ. I have written a book that I am going to present to the world in the next 12 to 16 months that talks about who wrote the Holy Scriptures, who was the mediator, and identifying the primary person that authorizes and gives authority and authenticity to both the Old Testament and the New Testament Scriptures. Jehovah, the God of Israel and of the Old Testament, did not write the intent and context of the scroll and/or books of the Old Testament Hebrew/Aramaic Scriptures. The Author and Originator of the Old Testament Scriptures is our Sovereign Father God. Jehovah God, the Mediator, is His Premier Prophet and also the Preeminent Intermediary between our Sovereign Father God and the remainder of creation. Jehovah God was the Sovereign Father's Prophet who gave the message to holy angels, who then gave it to Hebrew prophets. The only exception was Moses. He was the only Hebrew prophet to receive the message directly from Jehovah God, without the intervention of holy angels. Therefore, the created word out of Father God's mouth can heal you because it came forth and/or originated from the mouth of Father God. The Father is the God that John 1:18 says: "No one has seen the God at any time; the only begotten Son, who is from the bosom of the Father, has declared Him"; i.e., that Father God exists. Likewise the God of the Israel and of the Old Testament is the same God of the Church and the New Testament. In the

Old Testament and in Israel, “the Son of God” is called Jehovah God. In the New Testament and in the Church, “the Son of God” is called Jesus Christ. I’ve seen Jesus Christ in the spirit. I’m called to preach as a result of having seen the Son of God and having heard his voice calling me forth to walk in my destiny.

LH112 = I got a question for you . . .

TA113 = Uh huh . . .

LH113 = You mentioned that you have seen the Spirit . . .

TA114 = Uh huh . . .

LH114 = You’ve seen the Spirit and that what causes you to be called to preach . . . the Gospel

TA115 = That’s right . . . I’ve met the Lord Jesus Christ.

LH115 = Well let me ask you this, then . . . Do you believe in a Heaven and Hell?

TA116 = Yes, I do

LH116 = But we’ve seen nobody go to Heaven, and we’ve seen nobody go to Hell.

TA117 = Yes, I have seen people that went to Heaven. Because they lived in accordance with the word and will of God, I believe that they went to Heaven. If you live the life of faith in Jesus Christ, when you die, you will go to Heaven . . . Likewise I have seen others go to Hell. Because they lived outside the boundaries of the grace offered in the word and will of God, I believe that they went to Hell. If you live the life of doubt and disbelief, when you die you will go to Hell . . . Personally, I have not been to Heaven, and come back.

LH117 = That’s what I’m talking about . . .



TA118 = But I have seen people who have gone to Heaven . . . And I'll tell you right now, when my father and mother die, that is where they are going. I believe it with all my heart.

LH118 = Are they still living?

TA119 = Yes, they are still living

LH119 = That's wonderful, Praise the Lord

TA120 = They are approximately 88 and 85 years of age

LH120 = . . . My mom and dad are still living too.

TA121 = . . . The other thing that I have going for me is that, I died once.

LH121 = I did too . . . when I got shot

TA122 = I didn't see angels or demons at that time . . . I didn't go to Heaven or Hell.

LH122 = I saw my life flash before

TA123 = Ok, then . . .

LH123 = I thought about my dad and my mom, while I was laying in that ditch . . .

TA124 = In other words, you saw your life flash before you and then you thought about your mom and dad . . . Be very clear . . . You saw . . . and then you saw . . . those are two distinctly different things now . . . right?

LH124 = . . . That's true . . . I thought I was going to die . . .

TA125 = Now, the fact that you could see your life pass before you ought to indicate to you that the spirit world is real . . . that something inside of you separates from your breathing flesh . . . Now, let me tell you something, you can die not believing if you want to . . . But know this . . . there are consequences that come with that . . . The consequences are that you set yourself up for certain kind of experiences after you die. Now if you accept Jesus Christ as Lord and ask Him to come into

your life, you shall be saved . . . The problem we have is that we try to accept Jesus as Lord, and then want to turn and do our own thing . . . Please know this . . . Having “a redeemed live” in Jesus Christ is not living life by yourself. Instead, you are living life in conjunction with Jesus Christ as a continuous partner, 24/7.

LH125 = Then, I don’t need illegal drugs . . .

TA126= . . . You don’t . . .

LH126 = But you just can’t have a head knowledge of Jesus. You must have Jesus alive and living inside of your redeemed heart.

TA127 = Now, when Jesus lives in your heart and His presence is in you. When you begin to pray, different things happen . . . You can have power over drugs, power over sex, power over pain, power over the bullet and lead poisoning in your body, comfort in your mind, with legal and/or illegal drugs. There is healing available to your body because there is no disturbance and/or confusion caused by double signals which come from the interaction between legal and illegal drugs . . . See . . . Because, for instance; nicotine is a drug. And so, all of the things that you do can complicate matters in your body because you are setting up a scenario whereby you are going to be destroyed and your body will be in continuous pain and your body will not heal right and you’re going to heal slowly. You are going to have pressure sores on your body because this syndrome will set up an environment of confusion in your body through the presence of two kinds of drugs that may be acting in contrast to each other.

LH127 = I got you . . .

TA128 = Aside from total abstinence, the best thing that we can do is to try to determine which drug(s) will produce a good interaction and/or which drug(s) will produce a

bad interaction. And those things are very important when it comes to knowing which drugs will and/or will not tolerate each other within your body.

LH128 = What about people, places and/or things?

TA129 = Give me an example of what you're talking about.

LH129 = For example, where I live there are people in my building who smoke CRACK, and doing cocaine.

TA130 = . . . You mean, out there in that high-rise in that assisted living environment?

LH130 = . . . You see, where you live can make a difference. Because, for example, when I am at the VA hospital, I am going to meetings almost every day. I have a schedule and I have group sessions, individual counseling, Chaplain visitation(s), and participation in this project . . . the place or environment can make a difference. It made me feel good while I was there. But when I got out I slipped because I did not have the Lord in my heart.

TA131 = . . . You must believe that in every second in every day, Jesus is in tune and involved with all that happens with you and in you. In the salvation relationship, Jesus does not come and go in and out of your life. Jesus has come to stay continuously to live in your heart. You need to understand that even when you are using CRACK and doing other drugs, He's right there. But if you don't exercise your will and decide to turn to Jesus Christ, the circumstances that you find yourself in and the spirits that you encounter will continue to have control and victory over you.

LH131 = There are consequences . . .

TA132 = Yes, there are Consequences. For every action, there are consequences.

LH132 = . . . So, when they (i.e., *women*) come and knock on my door, what do I say to them?

TA133 = Just give them a mouth full of a NANCY REAGANISM: "Just say no to drugs," but add to it "in the name of Jesus, not today," one day at a time.

LH133 = Then, eventually they will get the hint . . . I got 30 day, man before I move out of my apartment. I feel because I think that it's just the surroundings like a nursing home. Cause in my present building, I get a lot of younger women coming in from outside. I'm tired of that environment, maybe a change will do me good . . . everything must come to an end. Plus I'm going to have my surgeries and get in a nursing home, take my TV and VCR. I'm going to leave everything else in that apartment and my clothes. They are welcome to anything and everything else they want. Because when I get out in six months to a year, I guess I can get me another apartment! At that time, I can get every thing that I need because I'm competent. I don't need a guardian and I haven't established a power of attorney. Nobody is in control of me, but the good Lord and my family. That's it. Nobody can tell me I can't come and I can't go because I never signed for a power of attorney. So when I get tired of a nursing home, I'll make a move. Plus, I got all of these applications that people have sent to me for apartments. You just can't just move into an apartment, you know . . . there are people obsessed with funning you (i.e., having fun at my expense). The problem that I have with them is . . . that there is a waiting list. But ain't gonna' worry about no apartment right now . . . The most import thing for me right now is to get my surgery over with, going into a nursing home . . . first give myself to God completely . . . that's what I need to do.

TA134 = Well, we are gonna' take care of that in just a few minutes.

LH134 = . . . And . . . all of these apartments . . . if it's meant to be, I'll get one, you know!

TA135 = Well now, the one thing that I want you to do, right now, is to take a pen and a piece of paper and write down a list of the things that you want . . . The second thing that I want to share with you is that reading the word of God is not a waste of time.

LH135 = . . . No, it's not.

TA136 = . . . And it's all because of who wrote it.

LH136 = Okay.

TA137 — . . . You must know that it originated out of the mouth of our Sovereign Father God. Thirdly, you must understand that the Sovereign Father and the Son of God are two distinctly different persons, and the Holy Ghost is separate and distinct from those two persons and personalities . . . you must believe this. The Holy Ghost does not have and has never had and will never have a body. He is only a Spirit.

LH137 = Is that the Trinity?

TA138 = Yes it is, in that it is Three, separate and distinct individual Godhead Persons . . . but not that Constantine, Athanasius, Council of Nicea, "three-in-one" stuff. The Son is the God of Israel and now is the God of the Church . . . Israel rejected that God, the Son who died on the cross, being crucified . . . but the Church and the Christians accepted Him, the Son, as the same God that the Israelites and the Jews rejected, even before the Son died, then after the Son died, and then after the Resurrection of the Son, from among the dead ones of Sheol/Hell . . . the same God, but the Jews and the Christians have a different relationship with the Son, in

that the Christians also recognize this same God as Creator, Sustainer, Elder Brother, Savior, Redeemer and Resurrector. The Jews call the Son by the name of Jehovah, and the Christians accept the Son and call that same God by the name of Jesus Christ [i.e., Jehovah, an Anointed Redeemer]. The expression in the bracket is just an explanation and elaboration of the meaning of the name the Christians use, i.e., Jesus Christ. He is His Sovereign Father God's first and only begotten Son. Father God allowed His only begotten Son to come forth and become the Creator of the world, of all things, both visible and invisible. And it is this Son of God who will be the Righteous Judge at the end of time, at the end of our lives, Ok? But now, it is the Sovereign Father God who authored and originated the word of God out of His own mouth and has established His first and only begotten Son as His Chief Prophet, Chief Priest, Chief Apostle, Master Teacher, Righteous Judge to all subsequently appearing creatures and/or instances of creation . . . past, present, and into the future. The Sovereign Father is the one who composed the words in Isaiah 53:5 as we will recite it according to the King James Version: He, the Son of God, was wounded for our transgressions; He was bruised for our iniquity, the chastisement of our peace was upon Him; and by His stripes, we are healed. In Isaiah 53:6-12 (KJV), the words that our Sovereign Father composed and authored continues: (6) All we like sheep have gone astray; we have turned every one to his own way; and the LORD hath laid on him the iniquity of us all. (7) He was oppressed, and he was afflicted, yet he opened not his mouth: he is brought as a lamb to the slaughter, and as a sheep before her shearers is dumb, so he opens not his mouth. (8) He was taken from prison and from judgment: and who shall declare his generation! For he was cut off out of the land of the living:

for the transgression of my people was he stricken. (9) And he made his grave with the wicked; and with the rich in his death; because he had done no violence, neither was any deceit in his mouth. (10) Yet it pleased the LORD to bruise him; he hath put him to grief, when thou shalt make his soul an offering for sin, he shall see his seed, he shall prolong his days, and the pleasure of the LORD shall prosper in his hand. (11) He shall see of the travail of his soul, and shall be satisfied: by his knowledge shall my righteous servant justify many; for he shall bear their iniquities. (12) Therefore will I divide him a portion with the great, and he shall divide the spoil with the strong; because he hath poured out his soul unto death: and he was numbered with the transgressors; and he bore the sin of many, and made intercession for the transgressors . . . If you earnestly believe these words that our Sovereign Father God has composed and spoken forth . . . then you have power with God, in Jesus Christ, the Son of God . . . Praise the Lord!

LH138 = *(His telephone rings. Afterwards, LH shares this with me . . .)* . . . This girl just called me man, let me share this with you . . . she's saying that I got her evicted from . . . How did I get her evicted man, you know . . .

TA139 = Does she live in your apartment building?

LH139 = No.

TA140 = . . . Is she a White woman?

LH140 = No . . . she's a Black woman . . . she's a sister, older woman . . . makes me feel bad . . . because I didn't have anything to do with that.

TA141 = Well then, what does she mean when she says that you got her evicted?

LH141 = . . . That's what she said to me . . . "I'm sorry you got me evicted," then . . . she hung up on me.

TA142 = How did you get her evicted?

LH142 = . . . That's what she said to me.

TA143 = Does she want to come and stay in your apartment, or something?

LH143 = No . . . she don't want to come up to my apartment. *(The telephone rings again . . . he ends the call briefly, and ends by saying "I'll call you back later" . . . then he turns to me and says . . .)* I'm just tired man . . . It's been a struggle, Chaplain, it's been a struggle . . . and I'm tired of struggling, man . . . like you said, I need peace; peace in my body, peace in my mind to release the anger . . . she's calling me telling me . . . I got her evicted . . . How did I get her evicted?

TA144 = Have you ever been to her house?

LH144 = No . . . she's been up in my apartment, smoking CRACK with me, man . . .

These White people watch Blacks, man . . . It's not that many of us, up in that city . . . I ain't trying to make no excuses, but many . . . A lot of White folk got that prejudice thing going; they don't really want Black people up in the building in the first place. She and I have been up in the building smoking CRACK before . . . maybe they saw her up in here before . . . maybe they've seen her up here or something, and then went down to the office and reported it, you know . . . And because of the reports . . . that's the reason that I have to get out of my apartment . . . I've got to get out of the apartment because of what people have said about me . . . I'm gonna be honest with you . . . I got to leave my apartment, man . . . I'm not leaving of my own free will.

TA145 = . . . Did they tell you that you have to go?



LH145 = . . . Exactly . . . they gave me 30 days . . . it ain't because I want to . . . I mean I want to because I want a new start. Maybe it's a blessing in disguise . . . some things are a blessing in disguise.

TA146 = Did they smell the odor of drugs coming from your apartment.

LH146 = No! It's just people on my floor, man . . . they keep watching and watching . . . speculation . . . most of it is speculation . . . On their part, it's speculation. But on my part, it's the truth . . . I did use drugs in here man . . . I mean, I know it's the truth . . . and God knows . . . it ain't speculation on His and my part. But on their part, it's speculation. They were not there when we were smoking that; they were not sitting on the couch while we were smoking and drinking and stuff, you know. It's just speculation. But, the reason I say that is to say this . . . it's time for a change man. I'm ready to go.

TA147 = I want you to do this for me . . . For the next six or seven weeks, I want to come and visit with you, once a week. I want to share some meditations, Bible verses to be memorized, Biblical interpretations, prayers and counseling sessions, about you, your life and newly established goals and objective for the near future. Ok?

LH147 = . . . At the nursing home?

TA148 = Wherever you are, I want to come and visit with you.

LH148 = I need to get your telephone number, so that I can get in touch with you. I'm gonna be in a nursing home.

TA149 = Ok. I'll do that . . . Right now, I want to have a word of prayer with you . . . I want to lay hands on you, in Jesus name . . . if you don't mind, Ok?

LH149 = Alright . . .

TA150 = We are going to pray together, right now, and ask Father God to give you deliverance from anger in our minds and in our hearts. Right now, I want you to see what we are doing and asking God for in your mind. By way of visualization, I want you to see in your mind, the place in Houston Texas where you had the auto accident and where you got shot. You were in an automobile, right?

LH150 = Yes Sir, in Texas . . .

TA151 = I want you to see that set of circumstances in your mind . . . I want you to see the place . . . In your mind, I want you to revisit it and re-experience the point in which the bullet penetrated your body, the beginning of the pain . . . and then the numbness . . . Were you in the back seat or the front seat?

LH151 = I was in the back seat at first. But I got in the front seat to talk to this sister because I was trying to RAP to her.

TA152 = . . . Was she driving?

LH152 = I was trying to RAP to her. If I had stayed my ass in the back seat, you see, I wouldn't have got hit . . .

TA153 = Uh huh . . .

LH153 = But I was trying to RAP to her . . .

TA154 = Ok! Now, I want you to repeat after me, word for word, Ok?

LH154 = Ok.

TA/LH - 154/155 (*In this prayer, the patient repeats the utterances of prayer, word for word*) = Father God, in the name of Jesus . . . I confess all my sins . . . I ask for forgiveness, and repent of my sins . . . I was in the wrong place . . . doing the wrong thing I repent in Jesus name . . . I acknowledge what I did . . . I am angry with the man who got me there and the woman who drove me there. I release them

from the anger and from the pain in my heart and in my mind and in my body . . . that resulted from me being in the wrong place doing the wrong thing. Again, I repent of all my sins and I ask for forgiveness in the name of Jesus. I forgive my brother who got me there and I ask you Father God to release me from him and him from me . . . to release me from the woman and the woman from me. And now I turn and literally give my pain and my anger to Jesus. I ask you Jesus, as you live in my heart, to take control of my life . . . to arrest me and relieve me of my anger and the pain that is associated with my anger. I now confess that in my life, I used illegal drugs to try to escape my immediate surrounding without leaving the location of these acts physically, trying to get away from loneliness and hurt without actually leaving the scene of my transgressions, and I participated in sex, using illegal drugs to cover up my feelings of inadequacy and the feelings of being only part of a man. I ask you Father to take from me the desire and appetite for crack, cocaine, amphetamines, alcohol, nicotine, and caffeine in the name of Jesus. I ask you Father to heal my body of the pressure sores that have not healed because of my use of illegal drugs in conjunction with my prescription medicine and because of my attitude of anger and because of my experience of the chronic pain that is in my body. I ask you Father God to reach into me and take from me this syndrome of anger, pain and illegal usage; to lift it up out of my body and cast it into the depths of Hell in the name of Jesus. I touch and agree with my brother as he lays hands on my head and on my heart. Now Father, in the name of Jesus, we curse the existence of this syndrome of anger, pain and illegal drug usage; we also ask for deliverance from sexual addictions and sex for the sake of sex and from pornography in the name of Jesus. We cast all of them into the depths of Hell

in the name of Jesus. We curse its seeds, its fruit, its shoots and its roots in the name of Jesus. We ask that the holy angels be dispatched to help us and to protect us, to keep our hearts, minds, souls, spirits, and emotions safe from hurt harm, danger and any other attack of the enemy. Keep us safe from The Devil/Satan, all other fallen angels, Beelzebub on every level of existence, and all other demons, demonic spirits and all other evil spirits from the heart, body, and the pits of Hell in the name of Jesus. Deliver us from the evil of mind control, will seduction spirits, attention stealing spirits, and focus destroying spirits. In the name of Jesus, come up out of his heart, out of his mind and out of his belly in the name of Jesus. And now, we cast all of them into the depths of Hell in the name of Jesus. Father, we ask you for a life that you will be pleased with and for a life that will please us. Specifically, we ask for deliverance in his back, in the place where the bullet is lodged up against his spinal cord; that you would seal it off, and that lead poisoning will come to an end in the name of Jesus. Thank you Father for answering our prayer; we believe it in our hearts and we accept the work of the Father as the fruit of the Holy Spirit. In the name of Jesus Christ, we pray. Amen, Amen.

LH156 = Wow! I needed that. Thank you Chaplain, I needed that.

TA157 =Now, I want you to write down these scriptures to read then daily, and/or during any part of the day or night, and include all verses. Okay!

LH157 = Alright . . . Ok

TA158 = Psalm 23, Psalm 46, Psalm 91. I want you to stay with those three passages of scripture. I want you to read them out loud to yourself. I want you to learn them for memory, and know they by heart . . . Do you have a tape recorder?

LH158 = No . . .

TA159 = If not, we will get one for you . . . I want you to record them in your voice.

Listening to the word of God produced by the sound of your own voice can be of great benefit to you and increase your capacity and ability to commit these passages of scripture to memory. God Bless you, my brother, in your efforts as we target the conclusion of this project. Amen.

LH159 = Thank you Chaplain. Thanks for coming to see me.

TA160 = Happy Trails to you, my brother.

LH160 = I remember that. That's an old Roy Rogers salute and greeting that he used to sing both at the beginning and ending of his TV program.

TA161 = . . . That's right, that's right. I surprised that you still remember it . . . some people do . . . Anyway, Happy trails to you, my brother, till we meet again.

After the third visit, the patient was discharged from the Louis Stokes VAMC, Cleveland Ohio and transferred to Brecksville VAMC Domiciliary facility. When the author became aware of the fact that Light Horse was being discharged, it was apparently good news for him because it meant that his pressure sores had healed faster than estimation of the hospital interdisciplinary team's treatment plan. Then, the patient returned to his apartment in Cuyahoga Falls, Ohio. I visited with him there, at a later date.

#### Preliminary Observation - 04/22/2004

The room of the patient was about the same in its appearance. There was no evidence of communication from outside of the hospital. There were handouts from various services organizations, etc. Also, there was evidence that the patient was making

use of his wheelchair and visiting the canteen, the cafeteria, junk food machines, chapel services and the weekly bingo games.

#### Verbatim Account // Conversation - 05/03/2003

No verbatim came forth from this visitation. There was no natural flow to our conversation, because the patient was not in a mood to fellowship. Therefore, the visit was brief, and cordial.

We completed the signing of the form and chatted briefly. Although the patient tried to be a little up beat, he was still kind of depressed both in appearance and in the tone of his voice. My gut feeling tells me that Light Horse understands what it takes to make the VAMC screws turn and make the VAMC doors open, so that he can process through the system, get off the streets, and/or be in line to gain access to a nursing home short list . . . the one under the control of the Social Workers.

#### 4a. Preliminary Observation - 08/03/2004

Patient has returned to the Louis Stokes VAMC Hospital and been processed into the Ward Thirty-one (31), the psychiatric ward. The patient reported hearing voices and encountered a spirit that that is telling him to kill himself. The patient reverted to his previous patterns of drug abusing behavior, using multiple forms of legal and illegal drugs. The author visited with the patient briefly and obtained written permission to use the content of our interview and access to his medical records to complete this project.

Verbatim Account // Conversation - 08/03/2004

TA = The Author, and LH = Light Horse

TA = . . . What's up with you, my brother? What are you doing in here? (The Chaplain was told that the patient was medicated, although he did not appear to be so)

LH = I slipped up Chaplain and reverted back to old habits . . . old habits die hard, you know.

TA = I won't take up much of your time today. I need you to sign this form, which gives me authorization to access your files . . . Do you remember our conversation about this requirement for access to your files on a previous visit?

LH = Yes, I remember.

TA = I do appreciate you seeing me today. I'll make sure that the Chaplains on duty come by for a visit. God Bless you Light Horse.

Case Study Evaluation and Analysis for Light Horse

(The Psychologist performed a combined evaluation of both SCI patients, *Da Drummer* and *Light Horse*, located previously in this document).

This is a Sociological evaluation of a case study, submitted by Chaplain Cheviene Jones in partial fulfillment of the requirements for degree the Doctor of Ministry, at United Theological, Dayton Ohio.

I, Claude Smith, write this evaluation from the perspective of a Licensed Social Worker and seminary student, at the request of Mrs. Earlie Williams, LISW, Supervisory Social Worker, at the Louis Stokes VAMC, Cleveland Ohio, for Chaplain Cheviene Jones.

I. *Give feedback about the effectiveness of the variables of pastoral care ministry:*

(1) Reflective Dialogue:

a. The Chaplain established a rapport with the patient and stimulated the patient intellectually. The patient showed a willingness to make a partial assessment of his problems in relation to the syndrome of anger, pain and illegal usage.

b. The Chaplain made good use of patient's strength in communication by re-phrasing, reflecting, and restating the patient's views with slight bits of added observational commentary and insights. In the use of Reflective Dialogue, the Chaplain made excellent use of "self." His introduction to the patient was formal and respectful, yet the Chaplain also came across as a very informed, resourceful, cordial and caring person. As the old adage says, "people don't care how much you know, until they know that you care." By employing Reflective Dialogue, the Chaplain made use of the patient's strong skill of verbalization. Because the patient has a C-6 spinal cord injury, as a paraplegic, he possessed a good range of motion in his upper body, having the use of his arms and hands, in the employ of his good verbal skills. The patient was able to articulate some of his needs, although at times they were rather simplistic. Because of the patient's situation, as it relates to the pain, anger and illegal drugs syndrome, he was at times rather limited in his understanding of the situation, which really reflected a poor self-image with feelings of low self-esteem and self-worth.

Because of the Chaplain's knowledge of sports, and their common interest in the same Dallas Cowboy football team, the Chaplain was able to get the patient to open up and become rather transparent, in the reflective dialogue. The Chaplain's use of "self" was quite masterful, because he was able to get deep into the psyche of the patient and help guide the patient toward a meaningful and realistic assessment of his problems.

In reflective dialogue, the Chaplain was able to get the patient to articulate some of his anger issues, where instances of healing could begin to take place. This is a



fundamental concern on a long-term care hospital ward where many of the patients live in varying stages of denial. The Chaplain appealed to Light Horse's sense of intellectual development and skills of verbalization in getting him to vent portions of his anger at a low level of intensity. By keeping the client focused, the Chaplain further enhanced their relationship in communication, using their mutual interest in sports and common history as disabled patients as a basis for moving him forward in the healing process.

Light Horse is very much the manipulator of subtle nuances of conversation and interpersonal relationships. In order for the relationship to continue to be mutually beneficial, the Chaplain must stay focused on the objectives at hand and stay on top of him in pursuit of the same in order to keep the patient focused, and moving toward healing.

It appears that the patient's lifestyle is the cause of him being in this situation. However, the Chaplain's use and sense of "self" and his level of competency in the use of this approach to ministry, afforded opportunities for him to encourage and uplift the patient and assist him in viewing life from a rather different perspective.

## (2) Biblical Interpretation and Meditations:

The Patient requested a King James Version Bible, which demonstrated his desire and ability to help change his situation using scriptural knowledge as a catalyst for change. Light Horse, the patient, did exhibit bits of self-control, which at this point in time was good, and that some of what he needed for guidance could come from the Bible.

His parents were Baptist and the patient had a warm affinity for them, especially his mother. Because of the patient's background and his identification with his mother, he showed some semblance of spirituality. He even showed some degree of familiarity with philosophy. The patient was delighted to know that the Chaplain did not consider it an

imposition to read scripture with him. And he sort of looked forward to the times when the Chaplain would visit with him.

(3) Prayer:

The patient was raised in the Baptist Church tradition. Prayer was requested by the patient and the Chaplain prayed for him. The Chaplain instructed the patient in the finer points of prayer as it relates to making sure that the patient knew exactly who he was praying toward and for what reason. Apparently, the use of the expression, “in the name of Jesus,” was appropriate and appeared to have had a healing effect upon the patient.

(4) Memorization of Bible Verses:

Light Horse did memorize some portions of Holy Scripture, but the role that the Chaplain played in this relationship was to keep him focused on Jesus Christ as a Healer because of his problems with the syndrome of anger, pain and drug dependency. The patient’s history suggests that, at times, he tends to slip back into a treatment recovery program as a safety net and being able to retreat to a “clean place.” He was willing to become a recidivist in the VA medical facility because of his pending surgery, pain and drug dependency. He needed to be reminded of the theological significance of prayer and the spiritual power that knowing God can bring to bear on effectively addressing the syndrome of pain, anger and illegal usage.

(5) Hospital Visitations:

The patient anticipated all visitations, but especially visits from the Chaplain. He did not get many visitors. Also, because of his usage of “crack cocaine,” the patient was attracting some of the wrong kind of people into his living environment. This was not beneficial to his medical health situation, however, at the end of his hospital stay, he did

get up enough strength to disconnect with certain lady friends with whom he smoked pot from time to time.

(6) Artistic Therapy and Counseling:

The patient made use of his Physical Therapy counseling, but I suspect that the patient looked up to the Chaplain as a kind of artistic therapist partner in reflective dialogue. I got the feeling that, despite his limited options, the patient was rather up-beat when the Chaplain completed his visit with him.

The Chaplain made good use of himself as a type of role model and artistic communicator with the patient. The patient was a relatively strong-willed person, in that at intervals he acknowledged a need to change his surroundings and enter into a clean place. Intellectually, Light Horse knew what to do, but he appeared to need affirmation from the Chaplain. Light Horse continued to wrestle with his choices: a drug lifestyle, dependency on women that used and abused him in order to gain access to the use of his finances; later on, dealing with being rejected by them.

*II, Tell how the presence of Chaplain benefited the patient*

The Chaplain masterfully used the technique of "lending a vision" to the patient, using the dynamics of reflective dialogue. The patient was greatly benefited by the Chaplain's presence. The patient appears to be intelligent and insightful in some respects, but continued to make some rather negative choices or questionable decisions, when he experiences depression episodes. I have the feeling that the patient was getting better in his perception of himself through therapy and continued Pastoral Care and counseling.

*III. Tell if and how the role of a Chaplain affected the patient's issues of:*

(1) Anger:

(a) The Chaplain helped the patient to see his anger and the negative effects of his anger against his struggle with the syndrome of pain and illegal drug abuse.

(b) The Chaplain appealed to patient's intellect as a means of addressing his problem through reflective dialogue.

(c) The Chaplain showed feelings of care and concern for the patient and exhibited an interest in him obtaining a complete deliverance from the throes of the syndrome of anger, pain and illegal drug usage. Initially, Light Horse acknowledged and talked about his anger issues.

Later on, he demonstrated some sense of trying to manage and/or manipulate the variables in his situation. In juxtaposition, the Chaplain used himself to affect issues in Light Horse's life, particularly to lessen some of his anger, in "talk therapy." He permitted Light Horse to ventilate his anger, while asking appropriate questions toward the end of the session. The Chaplain continued to show care and concern for the patient, while at the same time, the Chaplain showed strength and respect for the patient by appealing to his willingness to verbalize his feelings of anger.

(2) Pain:

The Patient was in pain and talked about his pain as he shared with the Chaplain that he takes a monthly regimen of prescribed painkillers and antibiotics. He shared that taking these prescription drugs makes him experience a numbing sensation in his back while giving him relief for only a couple of hours at a time. However, the patient not only alluded to the presence of his physical pain, but also to the psychological pain of being rejected, devalued, and used by the others and the system when his finances are depleted.

From a management point of view, the patient was realistic, most of the time, and even exhibited an unspoken sense of knowing exactly where he was in the cycle of his projected movement: from the VA hospital, to independent living quarters, to a clean place, back to independent living quarters, despite his paraplegic limitations and his lack of independent mobility. This was evident in that he was making plans, beyond his 180 days of VA patient care, to possibly entering into a nursing home facility, in the future.

Claude Smith B.S., MSSA

Retired Social Worker, LISW

Louis Stokes VAMC, Cleveland, Ohio

#### Pastoral Care Observation Summary

In the Pastoral Care Summary, the author is informed by the evaluations of the Clinical Psychologist, the Licensed Social Worker, and the Clinical Pastoral Education Supervisor as a Chaplain. The triangulation of the aforementioned evaluations informs the context of the implications of this four-part summary.

#### *Sociological Implication:*

As stated before, Light Horse is a 48-year-old African American Male, Vietnam era veteran of United States Army, an inpatient from Youngstown, Ohio. He is of the Baptist denomination. He was married previously. His father and mother are still living, but he seems to be estranged from them, so that he can do the things that he does to function in life. His spinal cord injury is the result of both an automobile accident and a gunshot wound occurring in Houston Texas. The patient's disability is not service connected. The patient truly believes that a change of a geographical location will give him a new start, a new lease on life. This is a setback from where I sit. However, the author is

not certain that Light Horse sees it from that point of view. And yet, the author believes that Light Horse knows exactly what he is doing, and exactly where he is in this debilitating, destructive process.

*Socio-economic Status:*

Light Horse is a lower class individual, not gainfully employed. He is a Disabled Veteran of the United States Army.

*Psychological Implications:*

Light Horse is a paraplegic, who maintains the use of his hands and arms. The trade-off is that because the bullet is lodged in his spinal cord, the use of his arms costs him a painful price. It is a price that includes the employ of very powerful painkillers to reduce to the intensity of the pain. Light Horse has poor self-image and self-esteem and lacks a healthy amount of self-worth. Light Horse is a depressed personality with serious anger issues. Coupling chronic pain with his growing anger and his use of illegal drugs, Light Horse's strong desire for sexual intimacy will increase significantly. The terms under which he engages the company of certain females will only attract women who will do anything to gain access to his financial resources. In their company, Light Horse naturally gravitates back to the use of illegal drugs. These relationships serve as a catalyst for an occasion for "a drug-induced instance of sexual intimacy." To some degree, he understands the dynamics and nature of this syndrome of anger, pain and illegal drug usage and where this synergy takes him. Though he often says he trying to keep it real, he is highly suspicious of the motives of anyone that he encounters anywhere because he has been used, misused and abused so often by those who offer to help him and/or those that he reaches out to. But his battles with depression, loneliness, and his desire for intimacy also allow him to rationalize that being abused and misused are the prices that he has to

pay to address his wants and needs and to obtain some sense of fulfillment. He will feel bad about it later on, but for the moment, he obtains a degree of satisfaction while under the influence of the combination of elements within this syndrome of addiction and torment.

*Spiritual Implications:*

The history of the patient's spiritual experience was in the Baptist Church. Presently, he is not active in the life of the Church. Since he lost his wife in Houston Texas after his auto accident and his spinal cord injury from a gunshot wound, the patient has never been completely active in the life of the Church on a regular basis. The author believes that Light Horse wants to love the Lord and wants to be a serious Christian. However, his desire to please the Lord in thought, word and deed are in a constant struggle with his desire for acceptance, sexual gratification and intimacy. Throughout our conversations, Light Horse verbalized that he knew right from wrong and he wanted to do the right things. But when his monthly disability check arrives, so does the temptation to have at least some vestige of intimacy in his life, even if it's only what his money can pay for within that fleeting monthly moment of pleasure, pain and passion. The fact that he is hearing voices can be an indication that certain spirits have targeted him and they believe that his desire to be satisfied physically and sexually is greater than his desire to please the Lord. For him, it seems that the price of being holy and doing things the right way is too high, and too lonely. At the same time, Light Horse states that he has a very grave fear of death and the possible consequences of eternal damnation. This is reflected in his occasional escape to independent living quarters at which time he enrolls in a nursing home or in a supervised assisted living facility. These facilities seem to be safe havens where, "the crack smoking and cocaine sniffing women," who usually arrive at his

apartment when his monthly check comes, do not have immediate access to him and his resources. Therefore, Light Horse has time for his conscience to clear and also time for his health to recover from the ill effect of countless binges that involve multiple forms of illegal drugs.

Yet we cannot forget the matter of the seething anger of Light Horse. His anger is the most powerful aspect of his syndrome of abnormal behavior, which requires that he abuse illegal drugs. It did not start out that way. But through the years, his many relapses into depression and his occasional reversions back to the use of illegal drugs has strengthened anger's hold on his mind, heart and his emotions. When he goes on binges using multiple illegal drugs in conjunction with his normal doses of prescription drugs, he escalates the lustful desires of his growing anger. Now, the anger of Light Horse permeates the whole of his personality and persona; eats at his guts, plays on his emotions, and causes him to see himself as a hurting, helpless and hopeless, part or half of a real man. He is spiritually damaged and very confused; relentlessly looking for what he presumes to be love in all the wrong places and with all the wrong people. Only a healthy dose of repentance and asking for forgiveness of sin toward Father God in the name of Jesus will rid Light Horse of the scourge or evil syndrome of seething anger, chronic pain, and illegal drug usage.

*Self-Evaluation:*

During the three visits that we shared together prior to his recidivism and return to the Louis Stokes VAMC, Psychiatric Ward, the author utilized the following: (1) reflective dialogue, (2) informal language, (3) colloquial expression, (4) relevant instances of self-disclosure, (4) memorization of scriptures, (5) Biblical Interpretations and instructions, (6) meditations, and (6) lively and insightful conversation. All of this was



done in an attempt to help the patient to take a critical and pensive look at the problems within his syndrome of anger, pain and illegal usage, within the controlled environment of the spinal cord injury unit of the Louis Stokes, VAMC, at Cleveland Ohio.

### **Discussion Of Data For Both Cases**

This discussion of data is based upon the content of the two case studies and evaluations by: the CPE Supervisor, the Psychologist the Social Worker and the Doctor and viewing this interrelated information as a synthesis against the enumerated items on the case evaluation form.

*Give feedback about the effectiveness of the variables pastoral ministry:*

*Reflective Dialogue:* In each instance, they communicated in a “man-to-man” conversation, non-judgmental, non-threatening, and accepting of each other as men of mutual worth. In each situation, creative use of the language and drawing for a base of common interest and information allowed the Chaplain to be an effective and insightful communicator. The genuineness, sincerity and transparency of the Chaplain was acknowledged by the patients and they responded to the presence of the helping role of the Chaplain in cordial, familiar, and trusting ways. The Chaplain understood the pain and anger issues with which each of the SCI patients had to deal and showed respect for the personal space, personhood and “the personal story” of each patient. Evaluations by the professional care from their areas of expertise alluded to the effective variable of pastoral ministry as an effective, insightful, sensitive and caring communicator and “counter conversationalist.”

*Prayer:* In the case of both Da Drummer and Light Horse instances, prayer was requested and well received as a meaningful and useful variable in the overall effectiveness

of the Chaplain. However, Light Horse appeared to be more aware of the need for prayer as a catalyst for change in motives and behavior. In the dynamics of prayer, we must always remember that the Sovereign Father is the object and receiver of the prayers and he understands the needs, even before we ask of him in the name of Jesus.

*Hospital Visitations:* The visitation of Da Drummer and Light Horse was the place where intervention took place, where all of the variables of Pastoral Ministry could be utilized: the power of presence, the power of power of approval and acceptance, the power of positive pastoral regard, and above all, the power of friendship. All of the professionals spoke of the structure of the mutually directed and motivated conversations and the free exchange of information between the Chaplain and the patients.

*Artistic Therapy and Counseling:* The professionals and the Chaplain agree that it is impossible to separate “Artistic Therapy” and “Reflective Dialogue.” In the creative use of “Artistic Therapy,” “Reflective Dialogue” becomes an integral part of the reflection, interchange and exchange of information in conversation. The content of each case study was different as it relates to stream of commonality. Central to each case was the isolation of a point of common, wherein the conversation would become more relaxed and informal, involving the use of semi-private words, slang terminology, and colloquial expressions to establish rapport and an atmosphere of trust and confidence.

*Tell how the presence of the Chaplain benefited the patient:* The Chaplain benefited the patients in that he shared of himself with them in both case study settings, in that he helped to create an atmosphere where they felt free to share personal and private concerns with him, a person to respect, admire, trust and confide in, on a wide range of issues. The Social Worker spoke of “*lending the patients a vision*” and assisting them in being able to articulate their feelings and concerns more clearly.

*Tell how the role of the Chaplain affected the patient's Anger issues:* From the research and data compiled from existing models, the Chaplain concluded that anger is such an indistinct quantity within human personality that varies in intensity and manifestation in both pre-injury and post-injury SCI patients. There is no rule of thumb that serves as a reliable indicator of dangerous levels of anger. The Chaplain was able to help each patient get in touch with anger in the sense of understanding its affect and manifestations in personality, conversation, and as an enemy of good health. Consequently, the Chaplain identified it, legitimized it, confronted it, and challenged it at some level of inquiry. In that sense, the Chaplain helped the patient to ameliorate anger and open discussions about disarming anger through the application of Biblical, prayerful, and scriptural remedies. The professional suggested that the Chaplain offered useful information about the anger and pain connection and the ill effects of anger, pain and illegal self-medication.

The Chaplain did not reduce the sensations of pain in the bodies of the patients, but did offer strategies for addressing the reality of pain from a theological and biblical frame of reference, particularly from a prayer and meditation point of view.

The research data from existing projects suggests that studies on pain management and the pain experienced by patients Spinal Cord Injury and Traumatic Brain Injury are worlds apart in that pain experienced by traumatized patients is often numbed for several but never completely eliminated. Extremely strong painkillers are a perpetual fact of life for traumatized patients.

Studies indicated that when it comes to the use of alcohol and/or illegal drugs usage by traumatized SCI and TBI patients, there are no "social drinkers" or "recreational

drug users”; they either abstain completely or they uses self-medicating intoxicant excessively.

### **Case Studies Conclusion**

Case studies intervention into the syndrome of anger, pain and illegal drug usage was a failure. Anger is such an indistinct quantity within human personality, which varies from person to person, and it is much, much more than an emotion or an emotional response. The hypothesis in pastoral care and the subsequent case studies were well intentioned. The professional evaluations by a CPE Supervisor, Clinical Psychologist, Licensed Social Workers, Medical Doctor, and Nurse Practitioner, were informative, encouraging, helpful and insightful. Nevertheless, the author must conclude that the results suggest that attempts to validate the hypothesis through a structured intervention program within a controlled environment failed. Particularly, the element of the hypothesis that dealt with illegal drug usage could not be addressed as an active component of the syndrome within the structured environment of the hospital setting. Yet, from the author’s point of view, the return of an SCI patient into the VAMC environment suggests that an indistinct synthesis of anger, pain and illegal drug usage syndrome was the determining factor in recidivism.

*Da Drummer* died in a nursing home in August of 2004, expiring within a controlled environment.

In August of 2004, *Light Horse* returned to the VAMC, after reporting to an emergency clinic intake nurse that “he was hearing angry and threatening voices.” Furthermore, toxins in the urine samples of *Light Horse* suggested that he relapsed into the use of illegal drugs. He confessed the setback in a subsequent interview. After

detoxification, the Chaplain must restart the process of ministry, support and/or confrontation, and re-educate the patient about the pitfalls of mixing legal prescriptions in conjunction with illegal drugs.

Anger and pain among SCI patients are such highly volatile explosive variables that are difficult to quantify. At best, the author can only make a qualitative estimation of the physiological and psychological effects of anger and/or pain in the life of a spinal cord injury patient at any given time. The primary thrust of the discipline of Pastoral Care suggests that the substratum of all existence is spiritual in nature. The syndrome of anger, pain and illegal drug usage must be acknowledged to have a component that is dysfunctional from a spiritual point of view.

Finally, there are different kinds of paraplegia and/or quadriplegia within the spinal cord injury patient population that manifest as different forms of mental, physical and spiritual impotence and/or dysfunctional behavior. Additionally, attacks upon the autonomic nervous by the Auto-Immune Deficiency Syndrome (i.e., AIDS) where healthy parts of the nervous system are perceived as viruses must also be taken into account, e.g., Multiple Sclerosis, Fibromyalgia, etc. And so, whatever the reason, this patient population experiences various manifestations of mental, physical and spiritual impotency, and exhibits dysfunctional behavior.

Therefore, whether persons are traumatized or untraumatized, all of us are embodied spiritual beings. The very essence of who we are and the substratum of what we are is "spirit based." Anger is not simply an emotion. Anger is a complex, multi-dimensional, covetous, possessive, proactive "spirit." The Holy Bible calls it the wrath of God from the Heavens. Anger must be addressed deliberately and intentionally from a Biblical, Scriptural perspective. More specifically, anger must be dealt with and subdued

within the family of God the Father in the name of Jesus Christ by the help of the Holy Spirit. Prescription drug therapy may be used to some degree for low-level maintenance in the early stages of a program of anger management. However, the weightier matters of anger are spiritual problems, which can develop into an evil heart of resentment, revenge and unbelief. This is a job for a Savior and/or Redeemer named Jesus Christ. Amen.

The syndrome of anger, pain and illegal drug usage becomes increasingly dysfunctional in the homes and living quarters of SCI patients. The author is determined to develop an ongoing, in-Home, Pastoral Care and Counseling, Visitation Ministry to the Spinal Cord Injury patient population. It is in the primary living quarters that anger, depression, alienation, rejection and isolation increase the propensity or tendency of Spinal Cord Injury patients to turn to and/or return to street drugs for illegal self-medication. We know that paraplegics and quadriplegics are not a highly mobile group of individuals. For the most part, they live and/or remain in the vicinity of their primary environments and/or surroundings. Case studies and observations suggest that a support system(s) of some description exists that helps them to obtain illegal self-medicating drugs through unhealthy and unsavory relationships. The author proposes to provide an alternative support system of an ongoing, in-Home, Pastoral Care and Counseling Visitation Ministry to the Spinal Cord Injury patient population.

## **CHAPTER SIX**

### **REFLECTIONS, SUMMARY, AND CONCLUSIONS**

#### **A Methodology For Affect/Results In Pastoral Ministry**

The author's methodology for obtaining optimum results from proponents of medical, sociological and psychological models of healing and wholeness is for patients of the Spinal Cord Injury population to fully cooperate with treatment plans and discharge plans, along with goals and objectives adopted by the Interdisciplinary Team. Because each person is multifaceted, none of the members of the interdisciplinary team must act alone. All of these parts of the interdisciplinary team must act in unison. Healing may very well come through a combination of disciplines.

All patients are encouraged to be responsible patients who act and/or react in answerable ways to members of the interdisciplinary team. In some instances, however, the patient is encouraged to participate in the creation and development of treatment plans in an attempt to get the patient to adopt the plan as his own and/or to buy into its implementation. The author never encourages patients to rebel against treatment plans and/or discharge plans or to disobey the Doctor's orders and the directions of the nursing staff. Yet, the author does acknowledge that it is a decision that the patient has the right to make for himself. Nevertheless, we know that occasionally there comes a time in the execution of the treatment process when alternative modalities of healing must be given serious consideration. The modality that we are suggesting can be enacted without

insurrection or rebellion on the part of patients, within the Spinal Cord Injury population. Therefore, the basis or support for the author's methodology of affect/results is a prayerful one. It is founded upon and/or grounded in his concept of the proactive spirituality of the Holy Bible for those who conform to the mandates of its intent and context for curative considerations.

The author's concept of spirituality is not secular, psychosocial scientific, philosophical, sectarian or ecumenical in its motivation. The basis for his context of spirituality is expressed in the intent and content of the collection of the Judeo-Christian Scriptures and his fixed ordered, hierarchical relationship with the Triad of members within the estate of the Godhead: (1) The Sovereign Father God, (2) His first and only Begotten Son God, Jesus Christ, and (3) God the Holy Spirit. When a patient within the Spinal Cord Injury population invites the Three Members of the Godhead into his/her pursuit of healing and wholeness, he/she augments the existing treatment plan and discharge plan without resorting to rebellion and disobedience.

This is the author's methodology for confronting the healing and wholeness needs of patients in the Spinal Cord Injury population so that they can be in position for them to possibly experience miraculous interventions by the Godhead. In *The Living Bible Paraphrased* (TLB), Hebrews 11:1 says: "*faith is the confident assurance that something we want is going to happen.*" In the New International Version of the Bible, Hebrews 11:1 says: "*faith is being sure of what we hope for and certain of what we do not see.*" In other words, patients in the Spinal Cord Injury population must engage in a faith/hope exercise of prayer and will in accordance with the word and will of God in order to be in position to obtain "the substance of things hoped for" and/or "the acquisition of the evidence of things not seen." This is the methodology of the Spirit of God that is



necessary when other tactics toward healing and wholeness are unprofitable and/or unproductive, if you have time to wait that long. The practice of medicine is important for the physical health and well being of the Spinal Cord Injury patients. The complementary art of nursing is necessary for foster a caring atmosphere of recovery and convalescence. The resuscitation and rehabilitation remedies of the physical and psychological aspects of the Spinal Cord Injury population are appropriate endeavors for sociological and psychological scientists. However, there are goals that this patient population must confront and objectives that the aforementioned disciplines cannot address because these goals and objectives are of a spiritual nature.

The capacity to have faith and the ability to believe can address the needs, goals and objectives of the Spinal Cord Injury unit population, which have escaped them through the employ of the theories and practices of the aforementioned scientific approaches to healing and wholeness. After a patient has tried all of the aforementioned approaches to healing and wholeness, it is never too late to begin to believe that his/her faith in the spiritual, supernatural processes of God can make a difference for him/her. Likewise, the patient needs to know that none of his/her efforts to believe toward Father God for the impossible and/or the improbable go unnoticed by Him. In His sovereignty, God can suspend the rules and constraints of science, erase the seeming advantage of sickness and disease, cancel the chemical power of drugs, decide to be proactive towards believers, and reward those who please him and diligently seek His face. No effort of faith towards our Father is too small or irrelevant before His Face. Comparatively speaking, hopelessness is worse than helplessness when you are in a life and death situation. For if a patient is truly hopeless, he/she is eternally helpless from a spiritual point of view, because he/she has ceased to reach towards the face of God for remedy and resolution.

Finally, to believe that our personal efforts of prayer can make things happen all by itself is an inverted misnomer. To be sure, it can be very frustrating and misleading for the neophyte Christian, the novice believer, and/or the prospective convert because answers to prayer do not always manifest themselves immediately. Literally speaking, it is often stated by some that “prayer changes things.” In and of itself, prayer does not change things. For if this “upside down” concept of prayer was true, it would represent an infringement upon the sovereignty of God. That concept or understanding of prayer is very different from believing that our Sovereign Father God is able to respond to and/or answer our prayers when we petition Him in the name of His Son, Jesus Christ. This is very different from espousing the erroneous principles of mind over matter, positive thinking and positive affirmations uttered by a man/woman, saved or unsaved. If that was the case, patients in the Spinal Cord Injury population could be healed and/or made whole through the simple initiation of certain kinds of wholesome processes of their minds in conjunction with the utterance of certain binding incantations. Prayer is a universal proposal requesting Father God to move in and/or act upon and even against our infirmities and/or diseases to heal us and/or to make us whole in the name of the Lord Jesus Christ.

Finally, the author intends to continue a ministry toward the members of the Spinal Cord Injury population both inside and/or outside of the hospital setting. The author intends to pursue the writing of a series of grants involving “home visitations” of SCI patients in an attempt to become a catalyst for change in habits and behavior, as well as to add an element of structure and order in the lives of patients who could respond positively when scheduled visitations to provide Pastoral Care are anticipated from a Certified Chaplain within their home environment.

### **A Personal Philosophy About Interacting With Others**

- In Private life
- In Personal life
- In Public life

We live in a world where identity fraud, the invasion of privacy and character assassination, the loss of your livelihood and life are facts of life. In this measured century of technical automation, high-speed telecommunications, and computer technology, some of our private records and personal files are readily accessible on the World-Wide Web (i.e., [www.xxx.com](http://www.xxx.com)) to those who employ the use of Internet search engines for research and investigation. In this millennium of financial, psychological, sociological, racial and sexual profiling, we are all subject to some form of scrutiny or investigation in one way or another. Additionally, there are many people in our society who major in gaining access to the personal resources and private lives of others for the purpose of preying upon the vulnerable, inattentive, unsuspecting, and/or the uninformed. Likewise, certain members of the workforce misuse and/or mishandle private and personal information about their fellow employees and/or supervisors, medical professionals and/or patients. As a careful observer of the tone and tenor human behavior in these times and/or in the author's environment, the author believes that we must develop a modus operandi of precaution that will address the matter of our safety and survival under the aforementioned circumstances. The recent institution of the HIPAA regulations in our society suggest that the right to privacy, the unnecessary invasion of privacy, and the question of business ethics are matters of top priority for the survival of this institution and the remainder of federal government organizations and/or installations.

To that end, the author has developed a personal philosophy about interacting with others, others being various and/or sundry members of a circle of family, personal friends, friends, associates, public acquaintances and/or enemies. At regular intervals, each of us must assess the ups and downs, triumphs and failures in our lives. The author has come to the conclusion that, for the most part, the world is not always a forgiving place, nor is it always a “user friendly place” to be in the process of interfacing with other persons and/or personalities in this stress-laden society. That is why it is so important to know who you are within yourself, separate and distinct from the judgments and evaluations of anybody else. The drama and dynamics associated with the occasions of anger and hostility within the population of the work environment is a microcosm of the troubling interpersonal relationships in the world in macrocosm. The author is a member of both the former microcosm and the latter macrocosm. Interrelationships begin to develop in hierarchical tiers and/or levels within a small number of intimate relationships. Then relationships multiply and increase both in density and complexity very much like the widening characteristics of a pyramid as it moves downward towards its base where there are larger numbers of less intimate relationships. Those closest to you will appear near the top of the hierarchical schematic configuration. Try as you might, there will still be those who will not like you for various reasons and will resist intense episodes of intimacy with you for whatever reason.

The author’s life is not an open book. Naively, the author tried this approach to living life in the early part of his adult ministry as a redeemed and empowered Christian. It did not work for him. He quickly abandoned the practice of arbitrary and/or indiscriminate self-disclosure. He soon learned that many people viewed uncensored openness and familiarity among strangers and mere acquaintances as a sign of weakness and immaturity

in a leader, Pastor and/or Chaplain. Idealistically, the inexperienced novice wants everybody to know him/her and also acknowledge and respect his/her office in ministry and wants everybody to like him/her unconditionally. The author was once an idealist and a novice. Finally, the author had to come to the conclusion that everybody does not like him and/or will not like him for whatever reason. In some instances, he created enemies just by existing as a person because of his appearance, his strengths, his weaknesses, his gifts and/or his shortcomings. In other instances, stressful situations and strained circumstances may portray him in an antagonistic role and/or adversarial posture momentarily or by happenstance. At the same time, he may not be aware of the fact that he has provoked someone to wrath and/or anger. Nevertheless, at some point in time, he must attempt to account for the presence of negative energy in his circumstances and/or unsuspected bumps in the road of his life's journey. Nevertheless, the author must respect the rights and privileges of others, and acknowledge their need for privacy and personal space, and covet the very same rights and privileges for himself.

There are many people in the world masquerading as someone else in demeanor and decorum. Either consciously or unconsciously, they are attempting to approximate the lifestyle script of some idealized role model's personality as they assume the role of "an imitator of life." This behavior is acquired either by reading a book, watching a play or movie, television, or living admiringly in the shadows of a seemingly overwhelming personality. They have placed their lives on hold and adopted what seems to work for them at the time. They are very subtle in thoughts, tentative with words and in deeds, trying to mimic what they think they see without understanding the underlying motives that drive their role model(s). They are interested in knowing everything about others without divulging who they really are and putting a lot of energy into covering up their

real motives for seeking intimacy. This is not true of the majority of humanity. But the frequency of uninformed mimicry in our society suggests that we must acknowledge these trends and tendencies. To that end, the author has come to the conclusion that he wants to be the one to determine who looks on the pages of his private and personal information and/or enters into his personal space. This is not paranoia, fear or insecurity. We just need to be aware of who is watching us and for what reasons, whether good or bad.

There are those who live life without a code of discipline or those who approach life without a strategy for engaging and/or encountering others. The author's experiences with anger, hostility, tragedy and betrayal suggest that he should establish some personal guidelines and boundaries surrounding the dramas, dynamics, and the interplay of interpersonal relationships in his life. He must also be aware of who is seeking to become acquainted with his private and personal information. As he has observed his interpersonal relationship with his family, friends, associates, acquaintances, and/or enemies/adversaries, the author has concluded that no one cares for him as much as he does. Furthermore, the author cannot expect others to manage his private and personal life for him at the expense of their own comfort and well-being. It is too much of a burden for anyone to care for him on an ongoing basis with remunerations and/or concessions of privacy.

The author's persona and his private life is his possession. He must manage it, safeguard it, and decide what part of his private and personal, life and history he will share with others, not as general/public knowledge, but sharing aspects of it on a need-to-know basis. To the best of his ability, he must determine who has access to him as a person and who has access to his personal and private history.

Within the bounds of his dominion and within the context of his resources, the author accepts responsibility for himself, the impressions that he makes, and the things that

he does. The author does not believe that everyone will like him and/or accept him and his views about his approach to living life. The author is not proud of all the things that he has done in his life. In some instances, the author is ashamed of himself and some of the things that he has done. The author thanks Father God for an audience before Him wherein confession, repentance and forgiveness of his sin(s) became a fact of history in His Son Jesus Christ and the mercies that He extends toward him in salvation and has registered him in the Lamb's Book of Life. In that context, the author does not frustrate the Gospel of Jesus Christ. Additionally, the author has forgiven himself. Because the author is a redeemed and empowered Christian man, he knows that his existence and dominion as a complementary counterpart within the body of Christ is established through the grace that Father God has given to him, in His first and only begotten Son, Jesus Christ. Therefore, the author has made the aforementioned declaration about his personal responsibility for himself as a former fallen son of the estate of Adam knowing full well that, as a willfully subservient disciple/priest in Jesus Christ, the author is accountable and will appear before the judgment of the Great White Throne for all deeds done or performed through and in his mortal body. All of these things are a part of either his individual identity and/or cumulative history.

Henry David Thoreau said: *"If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away."* Also read "Different Drummers," by David Kiersey. It was quoted previously in this manuscript.

Using the analogy of concentric circles, *the innermost circle* is a person's *private* life and history. *The intervening intermediate circle* is his/her *personal* life and history, and *the outermost circle* is his/her *public* life and history.

His/her *private* life and history is *confidential*. It is something that a person only shares openly or will share openly and uncensored with our Sovereign Father God, Jesus Christ and the Holy Ghost. Each person is the only human being within his/her private innermost circle of existence. Because we are the descendants of the fallen estate of Adam, there are times when even the most well-intentioned man/woman will have a slip of the lip and end up divulging the innermost secrets of another person, even when they are sworn to secrecy and confidentiality. In the author's experience of living life, he has found that many people have an inner circle of friends and/or family members that they tell almost everything, even the things they have sworn not to tell. Strangely enough, even when they have shared the private/personal business of others with their inner circle of friends and family, they feel justified within themselves to tell you that they have kept your confidence. Given that understanding, the author has opted to keep his private life and history concealed as best he can.

Each person's personal life and history is his/her confidential business as well. More specifically, it includes non-public information, delicate materials, special things and events that he/she holds in common, and in confidence with his/her spouse, parents, his/her immediate family members, brothers, sisters, nephews, nieces, and very close friends. It is also accurate to say that this *intervening intermediate concentric circle area* has a preferential hierarchy of access and priority. The spouse occupies the top position of preference within this intervening circle area, which is based upon a need to know about his/her personal business. Secondly, his/her father and mother, brothers and sisters, nephews and nieces, occupy the next position, within the preferential hierarchy of the intervening intermediate concentric circle area of his/her personal life and history.



A person's *public* life and history is freely available to all of his/her family, close personal friends, fair weather friends, acquaintances, and/or those who choose to act like enemies toward him/her. He/she is a community personality. He/she is a civic leader sharing communal responsibilities with other municipal leaders. It is his/her responsibility to maintain his/her private life and personal history separate and distinct from his/her public life and history.

Within the context and processes of our *Chaplaincy peer group associations*, we have agreed to mutually establish and thereby suspend some of the rules of engagement and/or conventions of encounter among our interpersonal relationships, both overtly and covertly. To some degree, we have added the element of "a mutually reciprocal trust factor" to our interpersonal relationships, occasionally renegotiating the remaining rules and/or terms of conventions as we move toward graduation day and/or Chaplaincy board certification. We have declared that our peer group is to be a *safe zone*. Our peer group is a *sanctuary* for us. It is a closed assembly where we approach the idea of self-disclosure and the revelation of our private and personal selves in an atmosphere of shared intimacy and trust, when we deem it to be relevant and/or beneficial for our understanding human behavior and/or self-knowledge, among peers.

When it comes to the question of interacting with patients on "the Spinal Cord Injury unit," it is a relatively safe place, separate and distinct from the macrocosm of society and the microcosm of the VA hospital. The author approaches it as a *private place in real time* where mutual respect and the unqualified acknowledgment of personhood generate authentic intimate encounters with fellow traumatized human beings. For the Spinal Cord Injury patient, interaction with others is not a priority and never will be. Likewise, dealing with the Chaplain, Doctor or Nurse, aside from alleviating the misery of

chronic pain, is not a priority within the mind of the average Spinal Cord Injury patient. Psychological and sociological pain(s) are not primary concerns; they are secondary. The Spinal Cord Injury patient is preoccupied with himself/herself, and personal issues of relief from chronic pain and discomfort. Within their, bodies, minds, and/or spirits, varying levels of seething anger, expressed or unexpressed, rise and fall like the swells and raging surfs of the returning tide when it comes in at night. Consequently, when it comes to the experience of interacting with patients on the Spinal Cord Injury unit, the Chaplain does not enter into conversation with them with a predisposition towards arbitrary self-disclosure. The Chaplain must understand that self-interest assumes the position of top priority with patients among the Spinal Cord Injury population. Every encounter that the author has with a Spinal Cord Injury patient as a Chaplain does not require that he practice indiscriminate self-disclosure. As best he can, the author tries to respect their right to privacy, acknowledge their need for personal space, and their never-ending quest for freedom from chronic pain and physical discomfort. The author is not always challenged to share some of his private life and personal history with the patients on the Spinal Cord Injury Unit. In most instances, they don't ask those kinds of probing questions. Occasionally, someone will ask the author about his personal and private life, but it is not something that he faces on a daily basis. From the perspective of the author, each experience that could involve some form of self-disclosure is evaluated as an individual incident unto itself, in and of itself, for its relevance to the situation at hand.

The average age of a majority of the Spinal Cord Injury patients is approximately fifty-five years old. They are predominately white male patients, World War II, Korean Conflict, and Viet Nam Era veterans. A majority of the Spinal Cord Injury veterans come to this hospital because they are dealing with serious health issues and/or coping with

varying levels of chronic pain and physical discomfort. In most instances, they ask very few questions about others because it is self-interest that consumes them. The conversations of the author with Spinal Cord Injury patients start out rather casual, and then gradually become more involved and more pointed, as the relationship develops and intensifies, over a period of time.

As stated before, the author is a Disabled Veteran of the United States Air Force. The author has something in common with Spinal Cord Injury patients and the matter of chronic pain. During the first half of his residency as a Chaplain Resident, at the Louis Stokes VA Hospital, the author experienced a recurring and agonizing, gnawing and excruciating pain of the sciatica nerve in his right leg. No amount of treatments, therapies and/or prescribed medications, gave him relief from chronic pain and physical discomfort. Without hesitation, he was predisposed to seeking a level comfort from the intensity of his pain. It was always on his mind. During that period of time, he was not given to engaging in unnecessary conversation about his private and personal life or the personal and private lives of other Chaplains or patients. He was consumed with self-interest issues in one way or another. He just wanted relief from chronic pain, physical discomfort, mental distress, and personal space to be preoccupied with himself and his pain.

**APPENDIX A**  
**REQUEST FOR AND AUTHORIZATION TO RELEASE**  
**MEDICAL RECORDS OR HEALTH INFORMATION**

201  
OMB Number: 2900-0260  
Estimated Burden: 2 minutes  
Expiration Date: 10/31/2004

# REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid MB number. We expect that the time expended by all individuals completing this form will average 2 minutes. This includes the time to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to specifically outline the circumstances under which we may disclose data.

The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED  
COMPLETE NAME AND ADDRESS IF SENDING TO THIRD PARTY

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

**INFORMATION REQUESTED** (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on \_\_\_\_\_ (date supplied by patient); (3) under the condition(s): \_\_\_\_\_

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at VA Regional Office that specializes in benefit decisions.

TE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

## FOR VA USE ONLY

PRINT PATIENT DATA CARD (Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

**APPENDIX B**  
**CASE STUDY EVALUATION FOR DA DRUMMER**

I. Give me feedback about the effectiveness of my variables of pastoral care ministry:

(1) Reflective Dialogue:

- a. The Chaplain used the Intervention of Identification as a basis for entering into the patient's space and establishing lines of effective interpersonal communications.
- b. The Chaplain used a portion of the principles of Reality Therapy, in the practice of the ministry of presence, in helping the patient to accept some sense of responsibility for his present situation and shunning irresponsible acts of rebellion against the treatment plan for him.
- c. The Chaplain helped the patient to confront issues of maladjustment which stems from the presence of Hidden Anger stealthily tucked away in his veneer of being cool and having his emotions under control,
- d. The Chaplain helped the patient to continue to hold on to a Vision for the future, a time in which the patient saw himself and getting up and walking out of this hospital.

I thought that this was an excellent study. The Chaplain used the intervention of identification to draw the patient out of denial and fostered an atmosphere that encouraged him to articulate appropriate responses to questions. The Chaplain's use of methods of clinical intervention was classic, in that it caused the patient to be forthcoming about the anger and depression lurking just beneath the surface of his personality and his public person of self-control.

The Chaplain and the patient shared the common bond of being former professional brother musicians at an earlier time in their lives. Reminiscing about their past musical experiences and sharing the lyrics and melodies of song common to both of their experiences made it possible for the development of a trusting, mutually beneficial relationship. Therefore, in the reflective dialogue, the patient is clearly disarmed in the

presence of the Chaplain and his defense mechanisms do not come into play in a significant way.

During his visitation with the patient, the Chaplain was able to introduce and at other times reacquaint the patient with the reality of his situation and help the patient to make better use of the principles of Reality Therapy. In reality therapy, the prerequisite to healing is accepting responsibility for the role that the patient played in the history of the events that acted as a precursor the present situation. In reflective dialogue, the Chaplain and the patient utilized slang terminologies and colloquial expressions characteristic of the African American experience and of the music industry to speak in a kind of semi-private manner when other VA hospital were within listening distance. Any fears and skepticisms that the patient had about the Chaplain, seemed to be dispelled when the Chaplain explained to the patient that a fellow musician, a lead guitar player, had inquired about him when he visited lead guitar player's business establishment.

Subsequently, the patient was comfortable enough with the Chaplain to share the anger that he felt with staff members who approached his mother about placing him a nursing home. The Chaplain allowed the patient to vent his anger. The reaction of the patient to the situation caused his anger to surface and the monitoring machines buzzer to be set off. In order to begin the process of addressing the anger, the patient had to deal with the reality of acknowledging that his hidden anger was inextricably tied to unforgiveness and unrepentance toward those who offend him. In many instances, the patient has so much hidden anger and unforgiveness that he needs to be confronted and resolved. In order for things to work out, the patient had to learn to forgive the offense of others, not only intellectually, but also emotionally. By making use of these things in a professional, yet compassionate, manner, the Chaplain was able to "lend the patient a vision."



## (2) Biblical Interpretation and Meditations:

The willingness on the part of the Chaplain to be open and transparent with the patient helped him to receive the reading and hearing of Biblical Interpretation and Holy Scripture and use it as a tool to help him come to grip with the need to begin the healing process with repentance and asking for forgiveness.

In the case study, the patient's records suggest that he was affiliated the Baptist Church. Apparently, both of his parents were of that orientation, prior to their divorce. Consequently, the patient's roots of spirituality were part of his upbringing. And now in the VA hospital, he was open to accepting some form of meditation, based on biblical themes and scriptures.

## (3) Prayer:

By his own admission, the patient had a belief in God. He turned to drugs to rid himself of some of his pain in his gut and in his emotions. Periodically, the victim would slip back into the world of illegal drug usage. Eventually, he came back and acknowledged that he needed prayer, and would eventually start all over again, from square one.

## (4) Memorization of Bible Verses:

The records suggest that he wanted he wanted a King James Version Bible. I believe that the patient memorized some of Psalm 23 and parts of Psalm 46 and Psalm 91, which were read to him, to help him when he was confronted by the demons of Satan. During hard times, when the patient slipped back into the illegal use of drugs, I believe that the reading of Bible verses to the patient enabled him to reach out for help.

## (5) Hospital Visitations:

The patient looked forward to the visits of the Chaplain and the sharing of common backgrounds in the nightlife and adventures with live Jazz and Dance Bands in the music industry in large metropolitan cities. The music became a catalyst for sharing and mutual bonding. Again, the colloquial expressions and slang talk helped to establish a

relaxed atmosphere and friendly surroundings wherein meaningful reflective dialogue could transpire between the Chaplain and the patient.

(6) Artistic Therapy and Counseling:

Using their common backgrounds as musicians, the Chaplain used the intervention of identification to make it easier for the patient to identify with him as a fellow musician. The use of the music, the singing of songs, the sharing of lyrics, and sharing tips about mastering unfamiliar tunes, helped the patient to relate to the Chaplain as an old familiar friend. From these songs and the implications of the words, the Chaplain could use that opportunity to draw parallels between the lyrics and real life issues. Humor was also a meaningful part of interpersonal communication between the Chaplain and the patient. However, because of the persistency of chronic pain issues, humor was not a consistent part of their reflective dialogue.

II. Tell me how my presence as a Chaplain benefited the patient.

From my point of view, the relationship between the Chaplain and the patient was primary and the objectives of the case study were secondary. There was a connection between the two of them that made the substance of their conversation have a distinct rhythm or cadence. They were on the same wavelength, kind of the same “vibe.” The ministry of presence can be very beneficial to those who don’t have anywhere to go, just hanging out and being in his room with no agendas and no demand for serious conversation.

III. Tell me if and how my role as a Chaplain has affected the patient’s issues of:

(1) Anger:

The Chaplain was aware of some of the traces of hidden anger still harbored by the patient. The Chaplain allowed the patient to vent the anger that he had directed toward the staff to be re-directed toward him in conversation as it relates to the staff approaching his

mother about giving them permission to place him in a nursing home. Secondly, the Chaplain acted as a liaison and/or advocate for the patient with the staff and encouraged the patient to at least listen to the staff's rationale about the time-line in his treatment plan.

(2) Pain:

It helped the patient to revisit the circumstances surrounding his receipt of the trauma to his spinal cord. As the patient shared with the Chaplain about being able to feel the bullet lodged in the back of his mouth and explained to him that the slightest movement of the bullet could produce sharp pains and great discomfort, the patient talked as if he was revisiting his earlier issues of anger and hostility toward the two brothers that he encountered back in his neighborhood. At that point, the Chaplain was able to raise the issue of forgiveness as a means of releasing the patient from the excess emotional weight and baggage of his past.

**APPENDIX C**  
**CASE STUDY EVALUATION FOR LIGHT HORSE**

1

I Give me feedback about the effectiveness of my variables of pastoral care ministry:

(1) Reflective Dialogue:

- a. The Chaplain established a rapport with the patient and stimulated the patient intellectually. The patient showed a willingness to make a partial assessment of his problems in relation to the syndrome of anger, pain and illegal usage.
- b. The Chaplain made good use of patient's strength in communication by re-phrasing, reflecting, and restating the patient's views with slight bits of added observational commentary and insights. In the use of Reflective Dialogue, the Chaplain made excellent use of "self." His introduction to the patient was formal and respectful, yet the Chaplain also came across as a very informed, resourceful, cordial and caring person. As the old adage says: "people don't care how much know until they know that you care."

By employing Reflective Dialogue, the Chaplain made use of the patient's strong skill of verbalization. Because the patient has a C-6 spinal cord injury, as a paraplegic, he possessed a good range of motion in his upper body, having the use of his arms and hands in the employ of his good verbal skills. The patient was able to articulate some of his needs, although at times they were rather simplistic. Because of the patient's situation as it relates to the pain, anger and illegal drugs syndrome, he was at times rather limited in his understanding of the situation, which really reflected a poor self-image with feelings of low self-esteem and self-worth.

Because of the Chaplain's knowledge of sports and their common interest in the same Dallas Cowboys football team, the Chaplain was able to get the patient to open up and become rather transparent in the reflective dialogue. The Chaplain's use of "self" was quite masterful because he was able to get deep into the psyche of the patient and help guide the patient toward a meaningful and realistic assessment of his problems.

In reflective dialogue, the Chaplain was able to get the patient to articulate some of his anger issues where instances of healing could begin to take place. This is a fundamental

concern on a long term care hospital ward where many of the patients live in varying stages of denial. The Chaplain appealed to Light Horse's sense of intellectual development and skills of verbalization in getting him to vent portions of his anger at a low level of intensity. By keeping the client focused, the Chaplain further enhanced their relationship in communication, using their mutual interest in sports and common history as disabled patients, as a basis for moving him forward in the healing process.

Light Horse is very much the manipulator of subtle nuances of conversation and interpersonal relationships. In order for the relationship to continue to be mutually beneficial, the Chaplain must stay focused on the objectives at hand and stay on top of him in pursuit of the same in order to keep the patient focused and moving toward healing.

It appears that the patient's lifestyle is the cause of him to be in this situation. However, the Chaplain's use and sense of "self" and his level of competency in the use of this approach to ministry afforded opportunities for him to encourage and uplift the patient and assist him in viewing life from a rather different perspective.

## (2) Biblical Interpretation and Meditations:

The Patient requested a King James Version Bible, which demonstrated his desire and ability to help change his situation, using scriptural knowledge as a catalyst for change. Light Horse, the patient, did exhibit bits of self-control, which at this point in time was good, and that some of what he needed for guidance could come from the Bible.

His parents were Baptist and the patient had a warm affinity for them, especially his mother. Because of the patient's background, and his identification with his mother, he showed some semblance of spirituality. He even showed some degree of familiarity with philosophy. The patient was delighted to know that the Chaplain did not consider it an imposition to read scripture with him. And he sort of looked forward to the times when the Chaplain would visit with him.

(3) Prayer:

The patient was raised in the Baptist Church tradition. Prayer was requested by the patient and the Chaplain prayed for him. The Chaplain instructed the patient in the finer points of prayer as it relates to making sure that the patient knew exactly who he was praying toward and for what reason. Apparently, the use of the expression, “in the name of Jesus” was appropriate and appeared to have had a healing effect upon the patient.

(4) Memorization of Bible Verses:

Light Horse did memorize some portions of Holy Scripture, but the role that the Chaplain played in this relationship was to keep him focused on Jesus Christ as a Healer because of his problems with the syndrome of anger, pain and drug dependency. The patient’s history suggests that, at times, he tends to slip back into a treatment recovery program as a safety net and being able to retreat to a “clean place.” He was willing to become a recidivist in the VA medical facility because of his pending surgery, pain and drug dependency. He needed to be reminded of the theological significance of prayer and the spiritual power that knowing God can bring to bear on effectively addressing the syndrome of pain, anger and illegal usage.

(5) Hospital Visitations:

The patient anticipated all visitations, but especially visits from the Chaplain. He did not get many visitors. Also, because of his usage of “crack cocaine,” the patient was attracting some of the wrong kind of people into his living environment. This was not beneficial to his medical health situation. However, at the end of his hospital stay, he did get up enough strength to disconnect with certain lady friends with whom he smoked pot from time to time.

(6) Artistic Therapy and Counseling:

The patient made use of his Physical Therapy counseling, but I suspect that the patient looked up to the Chaplain as a kind of artistic therapist partner in reflective

dialogue. I got the feeling that, despite his limited options, the patient was rather up-beat when the Chaplain completed his visit with him.

The Chaplain made good use of himself as a type of role model and artistic communicator with the patient. The patient was a relatively strong-willed person in that at intervals he acknowledged a need to change his surroundings and enter into a clean place. Intellectually, Light Horse knew what to do, but he appeared to need affirmation from the Chaplain. Light Horse continued to wrestle with his choices: a drug lifestyle, dependency on women that used and abused him in order to gain access to the use of his finances; later on, dealing with being rejected by them.

## II. Tell me how my presence as a Chaplain benefited the patient

The Chaplain masterfully used the technique of “lending a vision” to the patient, using the dynamics of reflective dialogue. The patient was greatly benefited by the Chaplain’s presence. The patient appears to be intelligent and insightful in some respects, but continued to make some rather negative choices or questionable decisions when he experienced depression episodes.

I have the feeling that the patient was getting better in his perception of himself through therapy and continued Pastoral Care and counseling.

## III Tell me if and how my role as a Chaplain has affected the patient’s issues of:

### (1) Anger:

(a) The Chaplain helped the patient to see his anger and the negative effects of his anger against his struggle with the syndrome of pain and illegal drug abuse.

(b) The Chaplain appealed to patient’s intellect as a means of addressing his problem through reflective dialogue.

(c) The Chaplain showed feelings of care and concern for the patient and exhibited an interest in him obtaining a complete deliverance from the throes of the syndrome of



anger, pain and illegal drug usage. Initially, Light Horse acknowledged and talked about his anger issues. Later on, he demonstrated some sense of trying to manage and/or manipulate the variables in his situation. In juxtaposition, the Chaplain used himself to affect issues in Light Horse's life, particularly to lessen some of his anger, in "talk therapy." He permitted Light Horse to ventilate his anger, while asking appropriate questions toward the end of the session. The Chaplain continued to show care and concern for the patient, while at the same time, the Chaplain showed strength and respect for the patient by appealing to his willingness to verbalize his feelings of anger.

(2) Pain:

The Patient was in pain and talked about his pain as he shared with the Chaplain that he takes a monthly regimen of prescribed painkillers and antibiotics. He shared that taking these prescription drugs makes him experience a numbing sensation in his back while giving him relief for only a couple of hours at a time. However, the patient not only alluded to the presence of his physical pain, but also to the psychological pain of being rejected, devalued, and used by the others and the system, when his finances are depleted.

From a management point of view, the patient was realistic most of the time and even exhibited an unspoken sense of knowing exactly where he was in the cycle of his projected movement: from the VA hospital to independent living quarters to a clean place back to independent living quarters, despite his paraplegic limitations and his lack of independent mobility. This was evident in that he was making plans beyond his 180 days of VA patient care to possibly entering into a nursing home facility in the future.

## BIBLIOGRAPHY

- Blackwell, Terry L. *The Spinal Cord Injury Desk Reference: Guide for Life Care, Planning and Case Management*. New York: Demos Medical Publishing, 2001.
- Childre, Doc, and Deborah Rozman. *Transforming Anger: The HeartMath Solution for letting Go of Rage, Frustrations, and Irritation*. Oakland, CA: New Harbinger Publications, Inc., 2003.
- Defoore, Bill. *Anger: Deal With It. Heal It. Stop It From Killing You*. Deerfield Beach, FL: Health Communications Inc., 1991.
- Egan, Gerard. *The Skilled Helper: A Problem Management and Opportunity-Development Approach to Helping*. Pacific Grove, CA: Brooke-Cole, Thomson Learning, 2002.
- Ekstein, Rudolph, and Robert Wallerstein. *The Teaching and Learning of Psychotherapy*. New York: Basic Books Inc., 1958.
- Ellis, Albert. *Anger: How to Live With and Without It*. New York: Citadel Press, Kensington Publishing Corp., 2003.
- Ellis, Albert. *Overcoming Resistance: Rational Emotive Therapy*. Springer Publishing Co., 1985.
- Frankl, Victor E. *Man's Search for Meaning*. Washington Square Press, 1963.
- Glasser, William. *Reality Therapy*. New York: Harper & Row Publishers, 1965.
- Hunter, Rodney J., H. Newton Maloney, Liston O. Mills, and John Patton. *Dictionary of Pastoral Care and Counseling*. Nashville, TN: Abingdon Press, 1990.
- Keirsey, David. *Please Understand Me II: Temperament Character Intelligence*. Del Mar, CA: Prometheus Nemesis Book Company, 1998.
- Kok, James R. and Arthur E. Jongsma, Jr. *The Pastoral Counseling Treatment Planner*. New York: John Wiley and Sons, Inc., 1998.

- Kolakowsky-Hayner, S. A., E. V. Gourley 3rd, J. S. Kreutzer, J. H. Marwitz, M. A. Meade, and D. X. Cifu, "Post-injury substance abuse, among persons with brain injury, and persons with spinal cord injury," 2002 Taylor & Francis Ltd. PMID: 12119077 [Pub Med - indexed for MEDLINE] July 2002. Department of Physical Medicine and Rehabilitation, Virginia Commonwealth University, Medical College of Virginia, Richmond, Virginia 23298-0542, USA. sakolako@hsc.vcu.edu. <http://www.ncddr.org/du/products/saguide/SubAbuse2ndEd.pdf>. Internet; accessed 20 September 2004.
- Kolakowsky-Hayner, S. A., E. V. Gourley 3rd, J. S. Kreutzer, J. H. Marwitz, D. X. Cifu, and W. O. Mckinley, "Pre-injury substance abuse, among persons with brain injury, and persons with spinal cord injury," *Brain Injury*. August 13, 1999. PMID: 10901686 [Pub Med - indexed for MEDLINE] Department of Physical Medicine and Rehabilitation, Virginia Commonwealth University, Medical College of Virginia, Richmond 23298-0542, USA. <http://www.ncddr.org/du/products/saguide/SubAbuse2ndEd.pdf>. Internet; accessed 20 September 2004.
- Maslow, Abraham H. *Motivation and Personality*. Harper & Row Publishers, 1970
- Nouwen, Henri. *The Wounded Healer*. Garden City, NY: Image Book, 1979.
- New Exhaustive Strong's Numbers and Concordance with Expanded Greek-Hebrew Dictionary* [CD-ROM] BibleSoft and International Bible Translators, Inc., 1994.
- Oates, Wayne. *The Presence of God in Pastoral Counseling*. Waco TX: Word Publishing, 1986.
- Peurifoy, Reneau Z. *Anger: Taming the Beast*. New York: Kodansha International, 2002.
- Rothstein, J. L., E. Levy, R. Fecher, S. K. Gordon, and W. A. Bauman, "Drug use and abuse in an urban veteran spinal cord injured population," *Journal of the American Paraplegia Society*. October 15, 1992. Veterans Affairs Medical Center, Spinal Cord Injury Service, Bronx, New York. <http://www.ncddr.org/du/products/saguide/SubAbuse2ndEd.pdf>. 2004 PMID: 1431868 [Pub Med -indexed for MEDLINE]. Internet; accessed 20 September 2004.
- Rustad, Lynne C. "An Investigation of the Relationship between Imaginal Processes and Motor Inhibition: The Fantasy Life of Paraplegics and Quadriplegics." Cleveland, OH: Department of Psychology, Case Western University, 1975.
- Seltz, M., and C. Radnitz. "The relationship of spinal cord injury trauma to alcohol misuse: A study of monozygotic Twins." *Journal of Spinal Cord Medicine*. (2004) Baumam WA.. PMID: 15156932 [Pub Med - indexed for MEDLINE]. Fairleigh Dickinson University, Teaneck, New Jersey 07666, USA. <http://www.ncddr.org/du/products/saguide/SubAbuse2ndEd.pdf>. Internet; accessed 20 September 2004.

- Soares, Joaquim J. F., and Beata Jablonska, "Psychosocial experiences among primary care patients with and without musculoskeletal pain," Received 14 August 2002; accepted 11 June 2003. Available online 16 December 2003. Unity of Mental Health, Samhallsmedicin (Department of Public Health Sciences, Division of Social Medicine, Karolinska Institute), Box 175 33, Wollmar, Yxkullsgatan 19, SE-118 91, Stockholm, Sweden. Internet; accessed 20 September.
- Tarvis, Carol. *Anger: The Misunderstood Emotion*. New York: A Touchstone Book, Simon and Schuster Inc., 1989.
- Williams, Cecelia A. "Pastoral Care to African American Males, ages: 18-35. Victims of Violence and their Families." D.Min. thesis, United Theological Seminary, 1998.
- Wilson, James L. *Adrenal Fatigue: The 21<sup>st</sup> Century Stress Syndrome*. Petaluma, CA: Smart Publishing, 2001.
- Yalom, Irvin D. *The Theory and Practice of Group Psychotherapy*. New York: Basic Books, 1995.